

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>TENNY D. ARBAUGH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 21, 1981</b>		2b. HOUR <b>9:40AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 19, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stone Mason Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Emp.</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Flintstone</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. Arbaugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula E. Pennington</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W.W.II 384-03-5947</b>	17. INFORMANT ADDRESS <b>Rebecca Golden, Cumberland, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CARCINOMA LEFT LUNG</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (H) (this hospital) attended the deceased from <b>2/15/81</b> , to <b>2/21/81</b> , that (H) (we) lost saw the deceased alive on <b>2/21/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. S. Nathan</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. A.S. NATHAN</b>		22e. ADDRESS <b>MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 26, 81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flintstone Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>William G. Knight</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 3 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY S. BECKWARD, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 9, 1981</b>			2b. HOUR <b>7:15A</b> M			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-6-1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>JANITORIAL</b>		
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY S. BECKWARD, JR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA GREENE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>KOREAN</b>		17. INFORMANT ADDRESS <b>ANN E. BECKWARD CUMBERLAND, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) Carcinoma of Rt-Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <b>Jan. 1981</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma, Rt-Lung</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Calvin Y. Hadidian</b> DEGREE <b>M.D.</b>						22c. DATE SIGNED <b>2/11/81</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CALVIN Y. HADIDIAN</b>						22e. ADDRESS <b>MEMORIAL HOSPITAL, MED. BLDG. CUMBERLAND, MARYLAND 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2-12-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEM PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEASURE-STEIN FUNERAL HOME, INC. CUMB, MD.</b>						25. DATE REC'D. BY REGISTRAR <b>FEB 18 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHAMBERLAND MEMORIAL HOSPITAL

DR. CALVIN A. HADGISON

1-13-1901

CHAMBERLAND, HARTLAND 21200  
MEMORIAL HOSPITAL, HET. BLDG.



Item 1 per. F.H.O. call 2816.13

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Theoda Theota</b>			MIDDLE <b>S.M.</b>			LAST <b>Bennett</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 22, 1981</b>			2b. HOUR <b>15:00PM</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 5 1894</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Home</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>		
						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>211 Holland Street</b>					
14. FATHER'S NAME FIRST <b>George</b> MIDDLE LAST <b>Collins</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Ann</b> LAST <b>Mountain</b>						ADDRESS <b>211 Holland Street</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>214-32-3709D</b>			17. INFORMANT <b>Frank Bennett</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> 19 <b>73</b> , to <b>2/22</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/12/73</b> 19 <b>73</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.														
22b. SIGNATURE <b>Kalun</b> DEGREE <b>MD</b>								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/22/81</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HALL MOS</b>								22e. ADDRESS <b>302 Schlegel Cumberland</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 25, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Silcox-Merritt</b>				ADDRESS <b>404 Decatur St</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Henry K. Brady</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH						2b. HOUR							
RUTH MARGARET BOWEN						Feb. 18, 1981						4:15 p.m.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD							
F		W		Jan. 21, 1929		52 YRS.		MONTHS		DAYS		Feb. 18, 1981 7 p.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
Maryland						U S A						Allegany							
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Frostburg						125 East Main Street						Teacher							
13a. STATE						13b. COUNTY						13c. CITY OR TOWN							
Maryland						Allegany						Frostburg							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						13d. INSIDE CITY LIMITS?							
Ivan						Shewbridge						Edith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT							
NO						213-24-8481						Miller Bowen same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:												Sudden							
IMMEDIATE CAUSE (a) Multiple Injuries												Sudden							
DUE TO, OR AS A CONSEQUENCE OF												Sudden							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:												Sudden							
(b) Vehicle struck by runaway tractor-trailer truck												Sudden							
DUE TO, OR AS A CONSEQUENCE OF												Sudden							
(c)												Sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED							
						4:15 p.m. 2/18/81						Driver of struck automobile							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY						21f. LOCATION							
						125 East Main St.						Main Street Frostburg Allegany Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE												TITLE (SPECIFY)				DATE SIGNED			
Benedict Skitarelic												M.D. Deputy				2/18/81			
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic M. D. ADDRESS Route #9 Cumberland, Maryland 21502																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY							
Burial						2/20/81						Frostburg Memorial							
24. FUNERAL DIRECTOR						23d. LOCATION						23e. DATE REC'D. BY REGISTRAR							
John J. Hafer, Jr.						Frostburg Allegany Maryland						FEB 23 1981							
NAME						ADDRESS						REGISTRAR'S SIGNATURE							
John J. Hafer, Jr.						LaVale, Maryland 21502						Benedict Skitarelic							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 5 5	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARCELLA NMI BRADLEY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1981		2b. HOUR 11:05 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7 MONTH 15 DAY 1913	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md			13b. COUNTY Allegany	13c. CITY OR TOWN Lonaconing	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Donald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Dawson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Donald Bradley Lonaconing, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> 2503 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal - Wilson Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr UNK UNK
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>80</u> , to <u>2-13</u> , 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>2-13</u> , 19 <u>81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>L. M. Ghick</u>				22c. DATE SIGNED 2-17	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>L. M. Ghick</u>				22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/16/81	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lonaconing A. Md
24. FUNERAL DIRECTOR NAME EICHORN FUNERAL HOME; 8 MAIN STREET, 21539		ADDRESS LONA CONING, MD		25a. DATE REC'D. BY REGISTRAR FEB 19 1981	
				25b. REGISTRAR'S SIGNATURE <u>Christy K. Brady</u>	



FEBRUARY 13, 1961

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 0 3 3 5 6					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					
Carleita Mae Briner					February 8 1981					
1 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Female		White		10 - 17 - 1925		55		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Md		U.S.A.				Allegany		Sears, Co		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Midland		O, Mara Avenue								
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS			
Md					Allegany		O, Mara Avenue			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Peter Briner					Hattie Beverage					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
no							Grace Briner Midland, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Multiple organ disease DUE TO, OR AS A CONSEQUENCE OF (c) Benignogenic Ca 6 mos									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 79 to Feb. 8, 19 81, that (I) (we) lost saw the deceased alive on Feb. 1, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
L.R. MILES, JR MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			2.9.81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
L.R. MILES, JR MD					LONA CONING MD 21539					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			2/11/81		Sunset Memorial Park		Cumberland County A. Md			
24. FUNERAL DIRECTOR					25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eichhorn Funeral Home					Lonaconing, Md.		FEB 15 1981			



February 8 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 5 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR	
MAUDE				FEB 9 1981	
3. SEX				2b. HOUR	
F				12 <sup>55</sup> A.M.	
4. RACE				5. DATE OF BIRTH MONTH DAY YEAR	
W				Oct. 10, 1892	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland				88 YRS.	
7b. CITIZEN OF WHAT COUNTRY?				9. BALTIMORE CITY OR COUNTY OF DEATH	
U S A				Allegany Co. MD.	
10. CITY OR TOWN OF DEATH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cumberland				Retired Sec.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12b. KIND OF BUSINESS OR INDUSTRY	
NURSING + CONVALESCENT CENTER				Clk. of Court	
13a. STATE				13b. CITY OR TOWN	
Maryland				Cumberland	
13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				406 Pulaski St.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
James M. Buley				Julia Diehl	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.	
No				220 44 5812	
17. INFORMANT ADDRESS				James H. House, Mt. Savage, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
CVA					
4360					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
old age					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/10 1972 to 2/9 1981, that (I) (we) lost saw the deceased alive on 2/11 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
P. E. ITALMO		MD		2/9/81	
22d. PHYSICIAN'S NAME (OR PRINT)		22e. ADDRESS			
P. E. ITALMO		302 Schley St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 11, 1981		Rose Hill Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Hafer Funeral Service. La Vale, Md.				FEB 17 1981	
				25b. REGISTRAR'S SIGNATURE	
				P. E. ITALMO	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Adam Able Carr, Jr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 4, 1981</b>			2b. HOUR <b>12:52 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 9, 1946</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE, (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>--</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>					13b. CITY OR TOWN <b>Allegany</b>		13c. STREET ADDRESS <b>Rd 3 Rawlings, Md. 21557</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam Able Carr</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dessie Rohrbaugh</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213 72 2785</b>		17. INFORMANT ADDRESS <b>Dessie Carr Rd 3 Rawlings, Md.</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>3314</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b> (c) <b>Hydrocephalus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Mental Retardation, Bronchitis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alleganer mo</b> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/4/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary Wagener, M.D.</b>					22e. ADDRESS <b>925 Bishop Walsh Dr. Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7 Feb 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maysville</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Maysville Grant W. Va.</b>		
24. FUNERAL DIRECTOR NAME <b>Allen Rotruck Keyser, W. Va.</b>					25a. DATE RECD. BY REGISTRAR <b>FEB 11 1981</b>		25b. REGISTRAR'S SIGNATURE		

Gary Simpson, M.D.  
 222 Bishop Welch Dr. Cumberland, Md.  
 21502  
 Serial 7 Feb 51  
 Lexington, Va.  
 Allen R. Koyser, M.D.  
 Lexington, Va.

No. 213 72 2733 See to Carr Rd 3 Rawlings, Md.

Name Able Carr Bessie

No. Allegany Rawlings x RDS Rawlings, Md. 21507

Cumberland Sacred Heart Hospital

U.S.A.

Allegany

White

Nov 2, 1946

34

Able

Carr, Jr.

Feb.

1951 7:32



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 0 3 3 5 9					
1. DECEASED NAME (TYPE OR PRINT) HARRY VERNON CLARKE				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1981				2b. HOUR 6:05 A	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Navigation Co.	
13a. STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George R. Clarke				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor B. Morgan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 562-24-0626		17 INFORMANT ADDRESS Rev. Paul C. Clarke Staten Island N. Y.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Heart Disease									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 2-25 1981, to 2-23 1981, that (I) (we) lost saw the deceased alive on 2-23 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Robustiano J. Barrera				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-23-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBUSTIANO J. BARRERA				22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 25, 1981		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.	
24 FUNERAL DIRECTOR NAME H. Wayne George, 202 Greene St. Cumb. Md.				ADDRESS 21502		25a. DATE REC'D. BY REGISTRAR FEB 27 1981		25b. REGISTRAR'S SIGNATURE L. J. Barrera	

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

FEBRUARY 27, 1961

VERNON CLARK

HARRY

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CUNBERLAND MEMORIAL HOSPITAL

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George R. Clarke 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

262-24-0626 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

DR. ROBERTO J. BARRERA 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

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FEB 27 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 0 3 3 6 0	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Harold Stanley Cooper</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2-3 19 81</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Dec. 26, 1911</b>	6. AGE (IN YEARS) <b>69</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Feb. 3 19 81</b>		7b. HOUR <b>6:40 a.m.</b>			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Sacred Heart Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>			
13a. STATE <b>W. Va.</b>										13b. CITY OR TOWN <b>Mineral</b>	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>none</b>	
14. FATHER'S NAME <b>David B. Cooper</b>										15. MOTHER'S MAIDEN NAME <b>Edith S. Bennett</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>										16b. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wife</b>										ADDRESS <b>Mrs. Dorothy Cooper, Wiley Ford, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Lobar Pneumonia, Bilateral</b> <b>1619</b> IMMEDIATE CAUSE (a) <b>Laryngeal Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Laryngeal Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Laryngeal Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>1 yr.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>2-3-1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Benedict Skitarelic MD</b>				ADDRESS <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-6-81</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>			
23d. LOCATION CITY OR TOWN <b>Artemas, Pa.</b>				COUNTY STATE							
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION



NOTES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1. FOR STATE REGISTRAR					8 1 0 3 3 6 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AUDREY ONETA CRABLE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 16, 1981</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 21, 1911</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		7b. HOUR <b>8:35A M</b>		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk &amp; Housew.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Variety Store</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Corriganville</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Hilltop Dr.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Warren -- Twigg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle V. Rice</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-28-9409</b>		17. INFORMANT ADDRESS <b>Miss Laurie May Hebb, P. O. Box # 238 21524</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metabolic alkalosis</b> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>81</b> , to <b>2/16</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>2/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Thaddeus H. Elder</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/18/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. THADDEUS H. ELDER</b>		22e. ADDRESS <b>MEMORIAL HOSP. MEDICAL BLDG. CUMBERLAND, MD. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/18/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park, Cumberland, Allegany Maryland</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b>		24b. ADDRESS <b>202 Greene St. Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1981</b>		
25b. REGISTRAR'S SIGNATURE <b>H. Wayne George</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2r. DATE OF DEATH MONTH DAY YEAR 02 15 81 2b. HOUR 10 <sup>06</sup> M			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola Johnson Decker		3 SEX FEMALE		4 RACE <del>Cauc</del> White		5 DATE OF BIRTH MONTH DAY YEAR 12 22 03	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIONS MANOR		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND 13b. COUNTY Allegany 13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 505 Cumberland St.	
14 FATHER'S NAME FIRST MIDDLE LAST George Lee Johnson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Belle Matheny		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO 212-38-6032A			
17 INFORMANT ADDRESS				17. INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1919 GIL BLASTOM				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 19 1919, to 2-15 19 81, that (I) (we) last saw the deceased alive on 2-13 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE MD				22c. DATE SIGNED 2-15-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Glick, Md.	
22e. ADDRESS Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB 16, 1981		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALT. MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS SILOOX-MERRITT FUNERAL SERVICE CUMBERLAND				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 6 3			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Laura E Dishong				2/17/81			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		04/ 03/ 06		74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Salisbury, Pa		USA				Allegany MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg, MD.		Frostburg Community Hospital		Homemaker		Own Home	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
Md				Frostburg		8 Howard St.,	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Robert Walker				Helena McKenzie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				213-50-9278		J Mallery, 48 Tarn Terrace, Frostburg, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Phematic Heart Disease; Coronary artery Disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A) WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James H. Tan</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Tan				22e. ADDRESS Broadway, Frostburg, Md 21532			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 19, 1981		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park, La Vale, Allegany, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md. 21532				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

United General Home, Frostburg, Md. 21532

Partial: Feb. 12, 1951. Sent to Mrs. Mary J. K. in wife, Allegheny, Pa.

Dr. J. J. Tan  
Frostburg, Md. 21532

*John H. Tan*

X

Enclosed please find a copy of the  
Frostburg Community Center  
Circular - 1951-1952

no 213-50-0270 J. Walker, 48 Tam Terrace, Frostburg, Md.

Robert

Walker

Walker

Walker

no

Allegheny

Frostburg

X

8 Howard St.,

Frostburg, Md.

Frostburg Community Hospital

Allegheny

Own Home

Salisbury, Pa.

USA

X

Allegheny

United

USA

PA

James

E

Allegheny

Salisbury

12:00a

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 3 6 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN L DYE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1981		2b. HOUR 10:35AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 12 1935		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER	12b. KIND OF BUSINESS OR INDUSTRY PAPER CUPS	
13a. STATE WV			13b. COUNTY MINERAL	13c. CITY OR TOWN KEYSER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME LUTHER			15. MOTHER'S MAIDEN NAME MARGARET GROVE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 233 50 2959		17. INFORMANT ADDRESS Roy Dye Sr. Keyser, WV.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11</u> 19 <u>80</u> to <u>2/28</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2/28</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>		22e. ADDRESS BMG, 912 SETON DRIVE, CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/3/81		23c. NAME OF CEMETERY OR CREMATORY Bloomington Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Bloomington Garrett Md.					
24. FUNERAL DIRECTOR NAME BOAL'S FUNERAL HOME		ADDRESS 111 CHURCH STREET WESTERNPORT, MD.		25a. DATE REC'D. BY REGISTRAR MAR 6 1981	
25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED 10-25-61

DATE

TIME

FROM

TO

RE

ATTENTION

ATTENTION

BY

BY

BY

ENTERED REPORT

COMPLAINT

DATE

BY

BY

BY

BY

DATE

DATE

DATE

DATE

SEE TO BE

on

xx

ENC. 912 SETON DRIVE, CHANDLER, N.H. 03022

for London County

London Co.

11/11

11/11

111 SOUTH STREET

10111 SOUTH STREET



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 3 6 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ORMA IRENE ELLIOTT			MONTH DAY YEAR FEBRUARY 10, 1981			7:30 P <sub>M</sub>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE	WHITE	MONTH DAY YEAR AUG 27 1890	90 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
PA.	USA		ALLEGANY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL		HOUSEWIFE					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
PA	BEDFORD	RFD3 BEDFORD	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD# 3 BOX 116 BEDFORD PA.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST MURRAY SIMONS			FIRST MIDDLE LAST JEANETTE MILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			183-40-0195			MYRTLE ROSE RFD3 BOX116 BEDFORD, PA. 15522		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete heart block</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> 19 <u>81</u> , to <u>2/10</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<u>[Signature]</u>								<u>2/13/81</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
DR. T.H. ELDER			MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			FEB 13 1981		P.O.S.OF A. CEMETERY		CENTERVILLE BEDFORD PENNA.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.			FEB 17 1981			<u>[Signature]</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



RECEIVED  
FEBRUARY 10, 1951 2:40 P.  
CH. BERLAND  
MEMORIAL HOSPITAL  
14  
STATION - TWO  
RECEIVED  
FEBRUARY 10, 1951 2:40 P.  
CH. BERLAND  
MEMORIAL HOSPITAL

CH. BERLAND  
MEMORIAL HOSPITAL  
14  
STATION - TWO  
RECEIVED  
FEBRUARY 10, 1951 2:40 P.  
CH. BERLAND  
MEMORIAL HOSPITAL

CH. BERLAND  
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FEBRUARY 10, 1951 2:40 P.  
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MEMORIAL HOSPITAL

CH. BERLAND  
MEMORIAL HOSPITAL  
14  
STATION - TWO  
RECEIVED  
FEBRUARY 10, 1951 2:40 P.  
CH. BERLAND  
MEMORIAL HOSPITAL

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH		2b. HOUR																	
CARL OLEN ELLIS																				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-16-81		2b. HOUR 2PM M																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR																									
Male		White		07-22-20		60 YRS.		MONTHS DAYS		HOURS MIN		19		4:20 PM																									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH																											
Pennsylvania				USA								Allegany MD																											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																							
Cumberland				Memorial Hospital---DOA								Retired				Tire Ind.																							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																															
W. Va.		Allegany		Paw Paw Side		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt./#:1 -Md. Side																															
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																																		
Bruce Ellis					Erna Ake																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS																													
Yes					War II					187-14-0487					Mrs. Rosalie A. Ellis, Rt. 1 Paw Paw W. Va.																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, RIGHT										SUDDEN																													
4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) CORONARY SCLEROSIS										----																			
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>										TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 1-16-81																			
EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D.										R.#(9, CUMBERLAND, MARYLAND 81118X21502																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial										2-19-81										Davis Memorial Cemetery										Cumberland Allegany, Md.									
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE RECEIVED BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Scarpelli, Cumberland, Maryland																				FEB 19 1981																			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BPMH-17  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03367	
1. FOR - STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Catherine M. Folk</b>										2a. DATE KNOWN OF DEATH <b>2-15-81</b>	
3. SEX <b>Female</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>June 30, 1918</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.										7b. HOUR <b>6p</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>2-15-81</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>										2d. HOUR <b>6p</b>	
10. CITY OR TOWN OF DEATH <b>Frostburg</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Hospital - DOA</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cafeteria</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>											
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Frostburg</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>329 Allegany St.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Clark</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Pearl Burdock</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>212-01-9654</b> 17. INFORMANT ADDRESS <b>Mr. Charles Folk, Frostburg, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Right</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. <b>4100</b> (b) <b>Coronary Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Old myocardial scarring of the posterior right ventricle</b>											
19a. DATE OF OPERATION <b>1-13-81</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Old myocardial scarring of the posterior right ventricle</b> 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>2-15-81</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic</b> ADDRESS <b>RD 9, Cumberland, Md. 21502</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>Feb. 18, 81</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Pk.</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>Durst, Frostburg, Md. 21532</b> 25a. DATE ISSUED BY REGISTRAR <b>Feb 14 1981</b> 25b. REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION

(K)

Case No. 100-100000

Re: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

Deputy

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 6 8	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST <b>Gertrude R. Foster</b>				MONTH DAY YEAR <b>02/01/81</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09/16/91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS. MONTHS DAYS HRS. MIN.	
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Comm Hospital</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Kandel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>213 74 4007</b>		17. INFORMANT ADDRESS <b>Mrs. Mabel C. Poland, Frostburg, Md. 21532</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest.</b> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease - Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years-Months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>1/28/81</b> , 19____, to <b>2/1/81</b> , 19____, that (I) <del>XX</del> lost saw the deceased alive on <b>2/1/81</b> , 19____, and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>XX</del> <del>XX</del> did not view the body after death.					
22b. SIGNATURE <b>Jesus Tan</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/16/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jesus Tan</b>		22e. ADDRESS <b>Frostburg, Md 21532</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>2/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland, Garrett, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 24 1981</b>			
24. FUNERAL DIRECTOR NAME <b>Bradley A. Stewart</b>		ADDRESS <b>Oakland, Maryland 21550</b>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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Dr. Jeeva Jan

SEIZED BY: 07/01/2017

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 0 3 3 6 9					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) IDA FRIEDLAND					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1981			2b. HOUR A 7:15 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 4 1897		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY ALLEGANY		13c. CITY OR TOWN LaVALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL SCHMIDT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE SCHMIDT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS HARRY MANDELL, LaVALE, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refraction CHF.</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>81</u> , to <u>2/23</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2/23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Halmos</u>			DEGREE MD			22c. DATE SIGNED 4/27/81			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER HALMOS					22e. ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAND 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-24-1981		23c. NAME OF CEMETERY OR CREMATORY AGUDATH ACHIM CEM			23d. LOCATION CITY OR TOWN COUNTY STATE ALTOONA BLAIR PENNA		
24. FUNERAL DIRECTOR NAME LEASURE-STEIN FUNERAL HOME, INC. CUMBERLAND, MD					25. DATE REC'D. BY REGISTRAR FEB 27 1981			25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>		



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JAN 10 1941  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORIAL HOSPITAL  
CHICAGO, ILLINOIS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03370	
1. DECEASED NAME (TYPE OR PRINT) <b>Curtis A. Garner</b>										2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> 2-7 1981	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1903</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>77 YRS.</b>	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>Feb. 8 1981</b>	2d. HOUR <b>4A</b>		2e. HOUR <b>3P</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Arms Apts.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>North Liberty St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ellis Garner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louis Sommerville</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			
16a. SOCIAL SECURITY NO. <b>220-16-5800</b>				17. INFORMANT ADDRESS <b>Daughter</b>				17b. ADDRESS <b>Mrs. Ramona Seib, Rt. 7, Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>2-8-1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Benedict Skitarelic MD</b>				ADDRESS <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 10, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpeilli, Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony Mal...</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 3 3 7 1	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>R PAUL GEORGE SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 9, 1981</b>		2b. HOUR <b>3:09P<sub>M</sub></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 20, 1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Coal Miner</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Allegany Cumberland</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>914 Harding Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles George</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Hott</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>193-01-3170</b>	17. INFORMANT ADDRESS <b>Sons Wilbur, R. Paul, Foster George, Cumberland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4860 Congestive heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD &amp; respiratory failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD &amp; respiratory failure</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/2/81</b> , 19 <b>81</b> , to <b>2/9</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>2/9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>NC Smith, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/10/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESPINA, RENATO M.D.</b>		22e. ADDRESS <b>907 SETON DRIVE., CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 12, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>SCARPELLI FUNERAL HOME, 108 VIRGINIA AVE., CUMB. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



Positive blood test  
Presumptive

Respiratory failure



2/10/81  
2/11/81

1/10/81  
1/11/81

2/1/81

1/10/81  
1/11/81

NOT SETON WITH...  
SOUTHERN NATIONAL HOME, 1105 VIRGINIA AVE.,  
ALBANY, N.Y. 12208

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FREDERICK A. GENTRY, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 26, 1981</b>			2b. HOUR <b>9:05AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 5, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		13a. STREET ADDRESS <b>Rt. 8, Valley Road</b>					
13b. STATE <b>MD</b>		13c. COUNTY <b>Allegany</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David S. Gentry</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Elizabeth Metz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>217 10 6979</b>		17. INFORMANT ADDRESS <b>Nancy L. Gentry Cumberland, MD Wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstructive Lung Disease</b>							
19a. DATE OF OPERATION <b>2-26-81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic Obstructive Lung Disease</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>CUMBERLAND, MARYLAND</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-23</b> , 19 <b>81</b> , to <b>2-26</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>2-26-81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William P. James</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/26/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. WILLIAM P. JAMES</b>				22e. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MARYLAND 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-28-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>JAMES F. SCARPELLI CUMBERLAND, MD</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FREDERICK A. GENTRY, SR. FEBRUARY 22, 1981 9:02 AM

CUMBERLAND MED. MEMORIAL HOSPITAL

DR. WILLIAM P. JAMES

401 N. CENTRE ST.  
CUMBERLAND, MARYLAND 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items #3&amp;6 Film G553 3/6/81 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 3 7 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BILLIE J GRIFFIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 17, 1981</b>			2b. HOUR <b>6:20 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH 1928 MONTH DAY YEAR <b>May 19, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>La Vale</b>		13c. STREET ADDRESS <b>Route 1, Box 193</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William T. Mitchell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Luteman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Daughters Ms. Evelyn Creamer, Ms. Bonnie Wright, City</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Bilateral Pneumonia</b> <b>5712</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Coronary (Scurvy's type)</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 12th</b> , 19 <b>81</b> , to <b>Feb 12th</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>2/16/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wally S. Hijab, M.D.</b>					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALLY S. HIJAB, M.D.</b>					22e. ADDRESS <b>909-A SETON DRIVE, CUMBERLAND, MD. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 20, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Vale, Allegany, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SCARPELLI FUNERAL HOME 108 VIRGINIA AVE. CUMBERLAND, MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 23 1981</b>		25b. REGISTRAR'S SIGNATURE		



ALLEGANY COUNTY, PA.      FEBRUARY 11, 1962      2:00 PM

TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL

RE:      DATE:      TIME:      PLACE:      BY:      FOR:      TO:      FROM:      SAVED HEART HOSPITAL



1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Angelina L Guido</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 27 81</b>			2b. HOUR <b>12:30</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 4, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Allegany County Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>111 Park Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Salvatora LaNeve</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sara Molinari</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Frank M. Guido Cumberland, MD Husband</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor - possible meningioma</b> 2252 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Urinary tract infection (C.V.A.)</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12 25</b> , 19 <b>80</b> , to <b>2 27</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>2 27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. Topper</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>3 1 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A Topper</b>					22e. ADDRESS <b>Hyndman Rd</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>		
24. FUNERAL DIRECTOR NAME <b>JAMES F. SCARPELLI</b>					CITY OR TOWN <b>CUMBERLAND, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 1 1981</b>		
					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This form may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(10)

April 10, 1918

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 4th inst. in relation to the matter of the above-captioned case. The same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
[Signature]

Enclosed for you are two copies of the report of the committee on the subject of the above-captioned case.

I am, Sir, very truly,  
Your obedient servant,

[Signature]  
[Title]

Very truly,  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 1 0 3 3 7 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ELBERT C. HAMPTON					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 6, 1981			2b. HOUR 1:22P <sup>M</sup>	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) B&O		12b. KIND OF BUSINESS OR INDUSTRY RR	
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6 Boone Street	
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Hampton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Connie Hampton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 251 18 3796		17. INFORMANT ADDRESS Betty N. Hampton Cumberland, MD Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Advanced COPD</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 3 1981 to Feb 6 1981, that (I) (we) last saw the deceased alive on Feb 6 1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>T. Williams</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-9-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS			22e. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-9-81		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk. Cumberland Allegany			23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND MD		
24. FUNERAL DIRECTOR NAME JAMES F. SCARPELLI			ADDRESS CUMBERLAND, MD 21502			25a. DATE REC'D. BY REGISTRAR FEB 13 1981		25b. REGISTRAR'S SIGNATURE <i>Maryland</i>	

BP

1900 FEBRUARY 6 1901

ELDER

CUMBERLAND, MD. MEMORIAL HOSPITAL

*Handwritten:*  
The following was  
received from  
the  
Cumberland, Md.  
Memorial Hospital

*Handwritten:*  
Feb 6 1901

MEMORIAL MEDICAL BUILDING  
CUMBERLAND, MARYLAND 21501

DR. TERRY WILLIAMS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03376	
1. DECEASED NAME (TYPE OR PRINT) <b>Nellie R. Hampton</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>2-14 1981</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 18, 1934</b>	6. AGE (IN YEARS) <b>46</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>Feb. 14 1981</b>	7d. HOUR <b>8P</b> M.		7e. HOUR <b>11</b> M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 9, Williams Road-Box 202</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 9, Williams Road, Box 202</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George O. Nelson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Ullery</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Children Carl L. Hampton, Jr. &amp; Barbara Turbin</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4512</b> IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, Massive</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Right Leg Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>24-48 Hours</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>					TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>2-14-1981</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Benedict Skitarelic MD</b>					ADDRESS <b>Cumberland, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-18-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>				



1881 FEB 12  
F. J. Kelly



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 1 0 3 3 7 7										
1- FOR STATE REGISTRAR CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE HENDERSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 15, 1981</b>			2b. HOUR <b>11:21 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 17, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Judge</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Circuit Alleg. Court County</b>		
13a. STATE <b>Md.</b>					13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert R. Henderson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louisa Patterson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Wars I &amp; II 212-38-5186</b>		17. INFORMANT ADDRESS <b>Mrs. Wm. Gunter, Cumberland, Md. Niece</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 days</b> 1 year										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Atrial fibrillation</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 5, 1981</b> to <b>Feb 15, 1981</b> , that (I) (we) lost saw the deceased alive on <b>Feb 15, 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas J. Devlin</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-16-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS J. DEVLIN, M.D.</b>			22e. ADDRESS <b>55 JACKSON STREET, LONA CONING, MD 21539</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-18-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>SCARPELLI FUNERAL HOME; 108 VIRGINIA AVE.,</b>			ADDRESS <b>CUMBERLAND, MD</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			



1961-11-10

ALLIANCE

STREET

1961-11-10

1961-11-10

1961-11-10

1961-11-10

1961-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 1 0 3 3 7 8									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
DANIEL M. HILEMAN					FEBRUARY 18, 1981			10:00A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		APRIL 17, 1909		71 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA				ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.		MEMORIAL HOSPITAL				RETIRED - STATE		ROADS DEPT.	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
PA.					SOMERSET		ADDISON		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FRANK					CLARA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					177-16-7659-A		MRS. DEBORAH HANFT, RT. 1, ADDISON, PA.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive lung disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>150</u> <u>4 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Atherosclerotic Cardiovascular disease.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/16/1981</u> , to <u>2/18/1981</u> , that (I) (we) last saw the deceased alive on <u>2/18/1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
[Signature]					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHY. DR. RIAZ JANJUA RIAZ A. JANJUA					22e. ADDRESS MEMORIAL MEDICAL BLDG., CUMB. MD. Memorial Hosp Med Bldg. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-21-81		ADDISON CEMETERY		ADDISON, SOMERSET, PA.			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Don Newman GRANTSVILLE, MD.					FEB 20 1981		[Signature]		

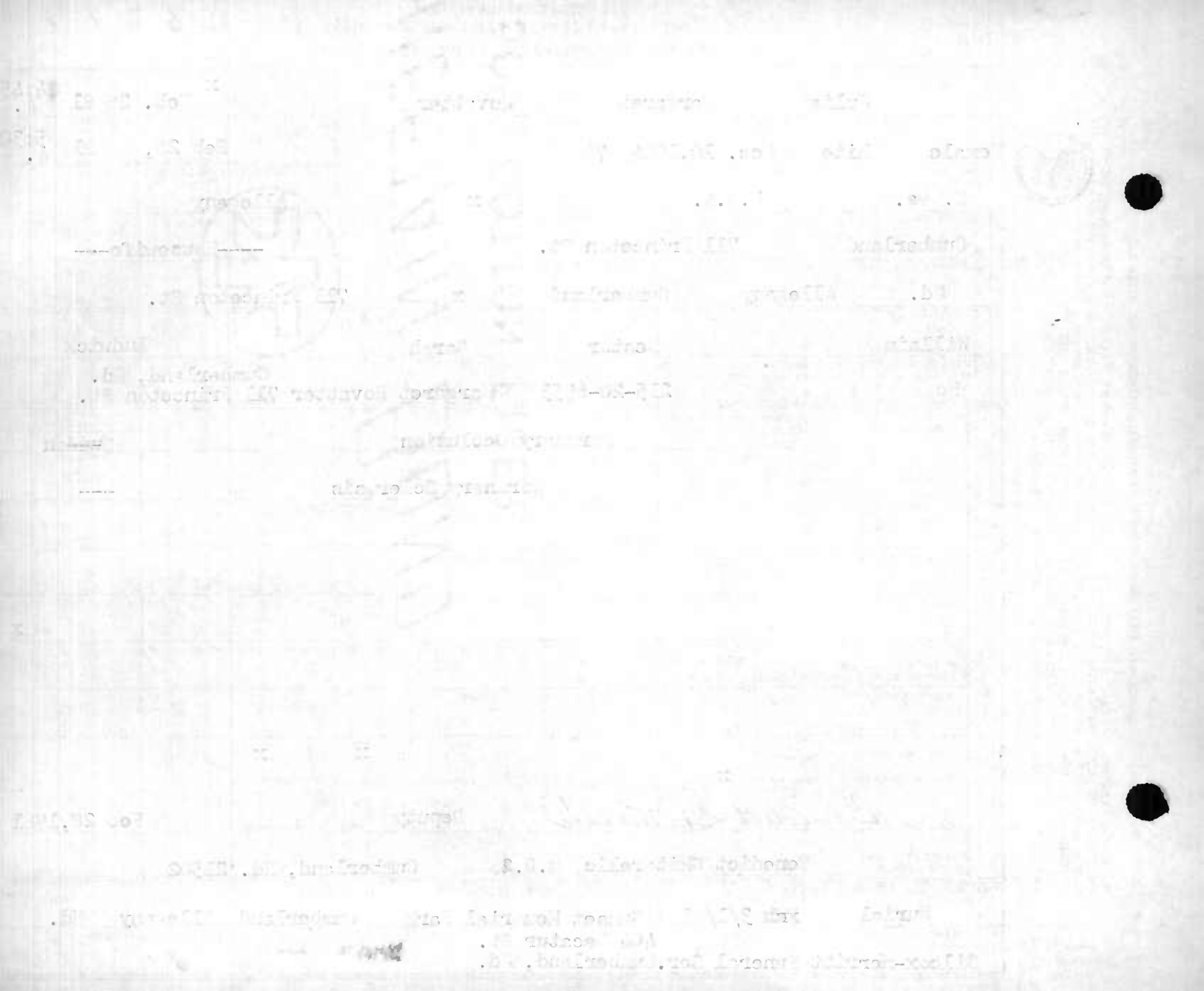
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03379	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Julia Margaret Hovatter</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>Feb. 28, 81</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 10, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <b>Beb 28, 1981</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>711 Princeton St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>711 Princeton St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willaim Nestor</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Ludwick</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-20-6953</b>		17. INFORMANT <b>Margaret Hovatter</b> ADDRESS <b>Cumberland, Md. 711 Princeton St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Coronary Sclerosis</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M.D.</b>						ADDRESS <b>Cumberland, Md. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 3/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Silcox-Merritt Funeral Ser.</b> ADDRESS <b>Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1981</b>		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 3 3 8 0	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN ELSWORTH JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR February 20 1981		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Bus Dr.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Beeman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-10-4501		17. INFORMANT ADDRESS John E. Johnson Jr. Barton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4409 } DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 60 to Feb. 20 1981, that (I) (we) last saw the deceased alive on Feb. 18 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L.R. MILES, JR. MD		DEGREE MD		22c. DATE SIGNED 2.23.81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.R. MILES, JR. MD		22e. ADDRESS Lonaconing Md. 21539			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 23-81		23c. NAME OF CEMETERY OR CREMATORY Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg Allegany Md.					
24. FUNERAL DIRECTOR NAME Eichhorn Funeral Home		ADDRESS Lonaconing, Md.		25a. DATE REC'D. BY REGISTRAR Feb 23 1981	
		25b. REGISTRAR'S SIGNATURE			



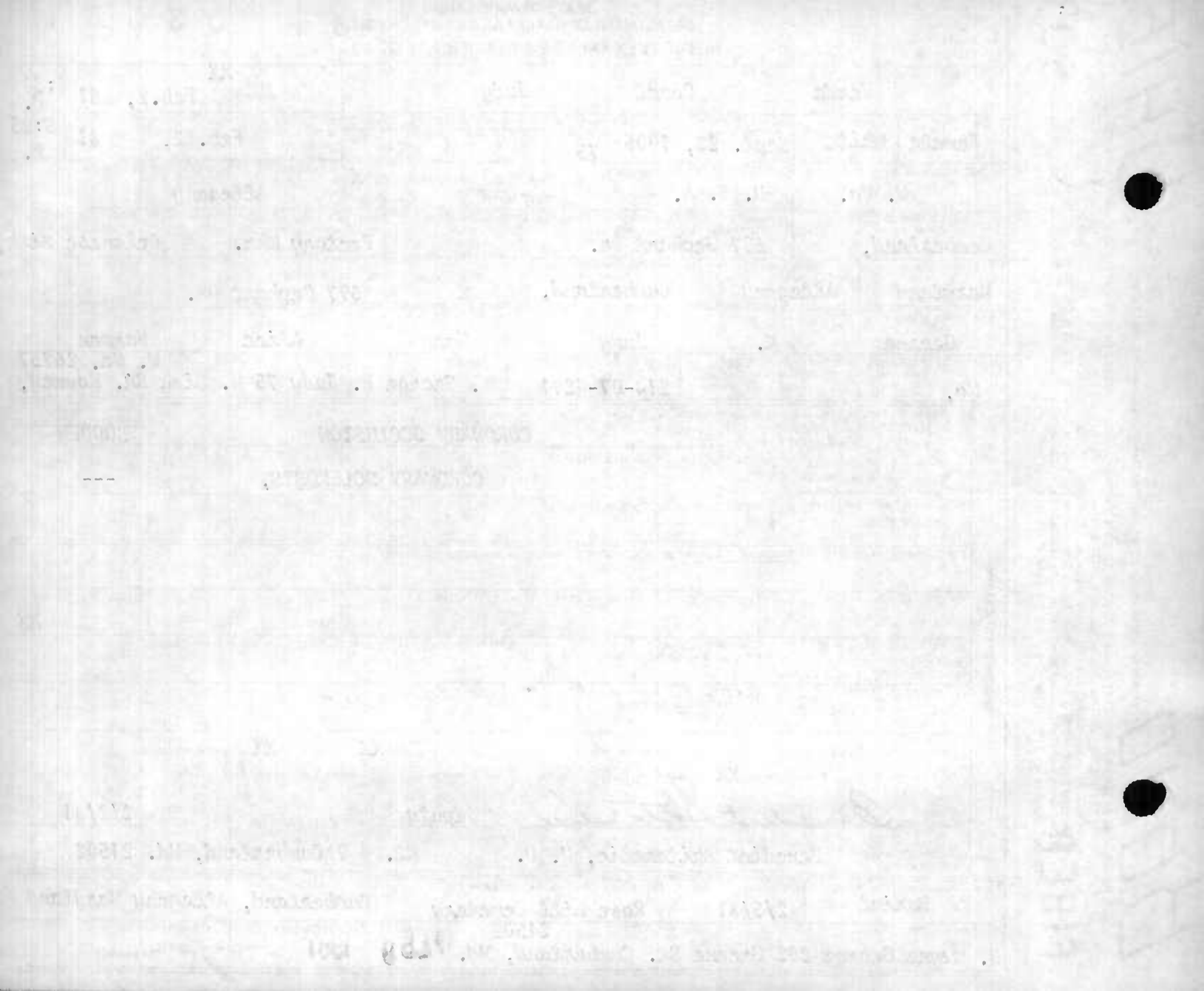


*[Faint, illegible text, likely bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15; ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03381	
1. DECEASED NAME (TYPE OR PRINT) <b>Verda Coral Judy</b>						2a. DATE KNOWN OF DEATH <b>Feb. 2, 1981</b>		2b. HOUR <b>4:30 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 23, 1905</b>		6. AGE (IN YEARS) <b>75 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>Feb. 2, 1981</b>		2b. HOUR <b>5:25 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland,</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>697 Gephart Dr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Wkr.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Silkh.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland,</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>697 Gephart Dr.</b>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>K.</b> LAST <b>Judy</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Alice</b> LAST <b>Harman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-07-4291</b>		17. INFORMANT ADDRESS <b>W. Va. 26757</b> <b>Mr. George E. Judy 75 N. High St. Romney,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY SCLEROSIS,</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>2/2/81</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M. D.</b>						ADDRESS <b>Rt. # 9 Cumberland, Md. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b> ADDRESS <b>202 Greene St. Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 8 2			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Virginia Kallmyer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>02-13-81</b>		2b. HOUR <b>12:15 A</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 28 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79-80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany Co.</b> MD.	
10 CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Village Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Frostburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>300 E. Main Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Roger Williams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Burton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>220-01-0541</b>		17 INFORMANT ADDRESS <b>At. Chart-</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest.</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Convulsion, apnoea, BSCVD</b> (c) <b>Organic brain syndrome, post Expt. lip</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 23, 1980</b> to <b>Feb 13, 1981</b> , that (I) (we) <input checked="" type="radio"/> saw the deceased alive on <b>Feb 13, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input checked="" type="radio"/> did not view the body after death.							
22b. SIGNATURE <b>Shin Eung Kim</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Shin Eung Kim</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>90 W. Main Street Westernport, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/15/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>German Lutheran</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg Allegany Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>57 Frost Ave. Frostburg, Md.</b> <b>Durst Funeral Home Maryland 21532</b>				25. DATE REGD. BY REGISTRAR <b>FEB 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Lucy H. H. H.</b>	



Great Imperial Home  
27 Post Ave. Rosbury,  
Weymouth, Dorset  
FEB 10 1961  
F. J. J. J. J.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 7 0 3 3 8 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRA L. KEMP			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 22, 1981		2b. HOUR 2:10 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 28, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Foreman	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE OF RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Pennsylvania ALLEGANY COUNTY			13b. CITY OR TOWN Hyndman	13c. STREET ADDRESS Hyndman, Pa. (Maryland Side)	
14. FATHER'S NAME FIRST MIDDLE LAST Orville R. Kemp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-1127	17. INFORMANT ADDRESS Mrs. Arvada Kemp, Hyndman, Pa. Wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt lower lobe pneumonia.</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>COP.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic cal of prostate</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>C.H.F.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>81</u> , to <u>2-22</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE <u>John Mehanne</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-23-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.		22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 25, 1981	23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardnes		23d. LOCATION CITY OR TOWN COUNTY STATE La Vale, Allegany, Md.	
24. FUNERAL DIRECTOR NAME SCARPELLI FUNERAL HOME		108 VIRGINIA AVENUE CUMBERLAND, MD. 21502		25a. DATE REC'D. BY REGISTRAR FEB 26 1981	25b. REGISTRAR'S SIGNATURE <u>Barry McQuinn</u>

2-10-5

FEBRUARY 20, 1951

MEMO

TO

FROM

ATTORNEY GENERAL

SACRED HEART HOSPITAL

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

cc

JOHN NEWMAN, P.D.

500 E. SEVEN DRIVE, GIBBSVILLE, MISSOURI 63021

1951 2 20

RECEIVED BY THE ATTORNEY GENERAL, FEBRUARY 20, 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 0 3 3 8 4			
1. DECEASED NAME (TYPE OR PRINT) LOLA BELLE KLINE				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1981				2b. HOUR 6:45 P.M.			
3. SEX Female,		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 28, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Don't Home			
13a. STATE Maryland				13b. CITY OR TOWN Corriganville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Along St. Rt. # 36			
14. FATHER'S NAME FIRST MIDDLE LAST Amos Luther Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha -- Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 215-20-6532		17. INFORMANT ADDRESS Mr. Earl K. Kline, P. O. Box # 94 Corriganville, Md. 21524							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> 4140 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Coronary Disease</u> (c) } DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>19 78</u> , 19 <u>81</u> , to <u>2-21</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>PAUL LIVINGOOD</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/25/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL LIVINGOOD, M.D.		22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/81		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION Cumberland, Allegany Maryland					
24. FUNERAL DIRECTOR NAME Wayne George		24b. ADDRESS 202 GREENE STREET CUMBERLAND, MD. 21502		25a. DATE REC'D. BY REGISTRAR FEB 27 1981		25b. REGISTRAR'S SIGNATURE <u>Lucy H. H. H.</u>					

BP



MAILED  
FEB 17 1961

RECEIVED  
FEB 17 1961

PAUL LIVINGSTON, JR.

100-200-0000

GEORGE F. ALMAY, CHAIRMAN

917 BENTON DRIVE, CLEVELAND, OH.

100-200-0000

428-17-1081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST GEORGE Francis KNIGHT			MONTH DAY YEAR FEBRUARY 20, 1981		11:05A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	MONTH DAY YEAR March 27 1913	67 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA		Allegany MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND	MEMORIAL HOSPITAL		Silk Screen Opr.		Advertising.	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland			Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Walter W. Knight			Anna V. Hendrickson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No			215-12-2308		Charles W. Knight Cumberland, Md. 421 Henderson Ave. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRA VENTRICULAR HEMORRHAGE</u> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRO-VASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JAMES M. RAVEN				22e. ADDRESS MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MARYLAND 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		Feb. 23, 1981		Sunset Memorial Park		Cumberland Allegany Md.
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
H. Wayne George, 202 Greene St. Cumberland, Md. 21502				FEB 27 1981		Robert R. Ralston

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 0 3 3 8 6			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD MARTIN LEASURE</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 26, 1981</b>				2b. HOUR <b>8:00 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 4 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Koppers Co.</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>WV</b>						13b. COUNTY <b>Hampshire</b>		13c. CITY OR TOWN <b>Greenspring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elsie Edward Leasure</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Pearl Hensrote</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>World War II</b>		17. INFORMANT ADDRESS <b>Ida Mae Leasure, Box 55, Greenspring, WV</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA Lung, metastatic</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>George M. Breza</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/27/81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE M. BREZA, MD</b>				22e. ADDRESS <b>912 SETON DRIVE, CUMBERLAND, MARYLAND 21502</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/1/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Glen Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenspring Hampshire WV</b>							
24. FUNERAL DIRECTOR NAME <b>Keith S. Shaffers</b>		24b. ADDRESS <b>230 E. MAIN STREET ROMNEY, WV</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							



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FEBRUARY 21 1961  
12:00 P

ALLEGAN COUNTY

SACRED HEART HOSPITAL

ALLEGAN

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ALLEGAN COUNTY

RECEIVED

ALL COUNTY, CLEVELAND, HAWKLAND, OHIO

GEORGE M. BERRY, JR.

200 E. MAIN STREET

ROCKY, MI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 8 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAMONA LEE LEIGHTY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 3, 1981		2b. HOUR 7:50A <sub>M</sub>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Employee,	12b. KIND OF BUSINESS OR INDUSTRY Celanese Silk, Park,	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland,	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Arthur F. P. McBride			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine K. Imler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 216-22-6875		17. INFORMANT ADDRESS Mr. Joseph L. Leighty, 12153 Marigold Ave. SW, Potomac Ph. Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) AS KID DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GI hemorrhage					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 year
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George Breza MD				22c. DATE SIGNED 2-3-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BREZA, M.D.				22e. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/81		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park,	
24. FUNERAL DIRECTOR H. Wayne George GEORGE FUNERAL HOME		25a. ADDRESS 202 GREENE STREET CUMBERLAND, MD		25b. BY REGISTRAR 25c. REGISTRAR'S SIGNATURE FEB 9 1981	
23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland					

BP



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116-22-4525-1-1 Albany County, New York

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ALBANY, N.Y. 12202

ALBANY COUNTY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 0 3 3 8 8				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
HARRY F. LEMASTERS					FEBRUARY 17, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR PM	
Male		Cau.		5/23/1899		81		7:02 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Wst. Virginia		USA				Allegany County		Tire Manu.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Maryland					Allegany		Box 156		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Fenton Clark LeMasters					Louise DeBolt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					219 03 9982		Memorial Hospital-Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Insufficiency</u> 10 days DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u> years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Concurrent Heart Failure, Chronic Lymphocytic Leukemia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>81</u> , to <u>2-17</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2-17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William P. James</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/18/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. JAMES					22e. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			2/20/81		Sunset Memorial Pk		Cumberland, Allegany, Md		
24. FUNERAL DIRECTOR NAME					25. DATE REC'D BY REGISTRAR				
Harvey H. Zeigler, Hyndman, Pa.					FEB 24 1981				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Beatrice M. Linaburg		Feb. 15 1981	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	Sept. 26, 1914	66
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Allegany MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	225 Grand Ave.	Housewife	Own Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Md.	Allegany	Cumberland	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
Ira Brashears	Mary Alderton	225 Grand Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
no		Mr. J. Whiting Linaburg, Husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Thyroid</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
1930			
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (i) (this hospital) attended the deceased from <u>8/2/8</u> 19 <u>76</u> , to <u>2/15</u> 19 <u>87</u> , that (i) (we) lost saw the deceased alive on <u>2/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Richard L. Snider MD</u>		<u>2/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Dr. Richard L. Snider MD		Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb. 18, 1981	Hillcrest Burial Park	Cumberland Allegany Md.
24. FUNERAL DIRECTOR NAME		25. DATE RECD BY REGISTRAR	
James F. Scarpelli, Cumberland, Md.		FEB 19 1981	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	0	3	3	9	0
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>CYRUS T. LIPSCOMB</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 11, 1981</b>					2b. HOUR <b>11:15</b> P M						
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 14, 1896</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany Co.</b> MD.								
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>K&amp;S Tire Co.</b>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Allegany</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Route 6</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elemeul M. Lipscomb</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Van Meter</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT <b>Mrs. Radie K. Lipscomb, as above</b>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Marked Respiratory Failure, RIGHT</b> <b>4900</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Diminished Pulmonary Reserve</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Previous carcinoma of left lung: Prev Left Pneumectomy</b>																
19a. DATE OF OPERATION <b>1979</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>2-2-81</b> to <b>2-11-81</b> , that (I) (we) lost saw the deceased alive on <b>2-11-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Richard Schindler</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>2/12/81</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. RICHARD E. SCHINDLER</b>					22e. ADDRESS <b>69 GREENE STREET CUMBERLAND, MARYLAND 21502</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Vale, Md.</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>John J. Hafer, Jr. La Vale, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Forney</i>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 9 1	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST HERBERT D. LONG				MONTH DAY YEAR FEBRUARY 19, 1981	
3. SEX Male		4. RACE White		5. DATE OF BIRTH	
				MONTH DAY YEAR Nov. 1, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
				12b. KIND OF BUSINESS OR INDUSTRY Sand Quarry	
13a. STATE Md.					
13b. COUNTY Allegany					
13c. CITY OR TOWN Cumberland					
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS Route 1, Lower Homewood Add.					
14. FATHER'S NAME FIRST MIDDLE LAST unknown					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					
17. INFORMANT ADDRESS Mrs. Violet Smith, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>					
4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<u>Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-9</u> 19 <u>81</u> , to <u>2-19</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2-19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William P. James</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/22/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM P. JAMES		22e. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 23, 1981		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 24 1981	

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1 - FOR  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 3 3 9 2

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. MONTH DAY YEAR		2c. ESTIMATED		2d. HOUR	
Henry		B.		Lowther		Feb. 19, 1981		5:00 p.m.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD	
Male		White		Jun. 22, 1907		73 YRS.		MONTHS		DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.		USA										Allegany MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Memorial Hospital DOA		Carpenter Contracting Co.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		Allegany		Flintstone		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Star Route					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Oliver		Emma		A		Stewart							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WWII		706-16-0634		Sister		Laura Lowther		Flintstone, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:		CORONARY OCCLUSION		SUDDEN									
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF											
4100		CORONARY SCLEROSIS		DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1)		CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
				STREET									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Benedict Skitarelic		TITLE (SPECIFY)		DEPUTY		DATE SIGNED		Feb. 21, 1981			
EXAMINER'S NAME (TYPE OR PRINT)		BENEDICT SKITARELIC, M.D.		ADDRESS		RT. # 9 CUMBERLAND, MD		21502					
23a. BURIAL CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		Feb. 23, 1981		IOOF Cemetery		Cumberland		Allegany		MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
William G. Knight		Cumberland, MD 21502		FEB 25 1981									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03393		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie L. Maddy										2a. DATE KNOWN OF DEATH 2-11 19 81		2b. HOUR 9A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 27, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD Feb. 12 19 81		2d. HOUR 1A M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.						
10. CITY OR TOWN OF DEATH La Vale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 51 La Vale Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 51 La Vale Blvd.				
14. FATHER'S NAME FIRST MIDDLE LAST Ungar Mellott					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Shaffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mr. Charles L. Maddy, Cumberland, Md. Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE Feb. 12, 1981				
EXAMINER'S NAME (TYPE OR PRINT) Dr. Benedict Skitarellic MD		ADDRESS Cumberland, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-14-1981		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md.				25a. DATE RECEIVED BY REGISTRAR FEB 17 1981		25b. REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 3 9 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KENNETH H. MAHANEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 1, 1981</b>		2b. HOUR <b>8:09A<sub>M</sub></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 21, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Taylor H. Mahaney</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Hoenicka</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>War II 214-07-3469</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret Mahaney, Cumberland, Wife</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)  
**4100**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-1</b> , 19 <b>81</b> , to <b>2-1</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>2-1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robustiano J. Barrera</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2-2-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ROBUSTIANO J. BARRERA</b>				22e. ADDRESS <b>MEMORIAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 4, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1981</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FEBRUARY 1, 1961 KENNETH W. HANNEY



CHAMBERLAND, MD. MEMORIAL HOSPITAL

JAN 11 1961

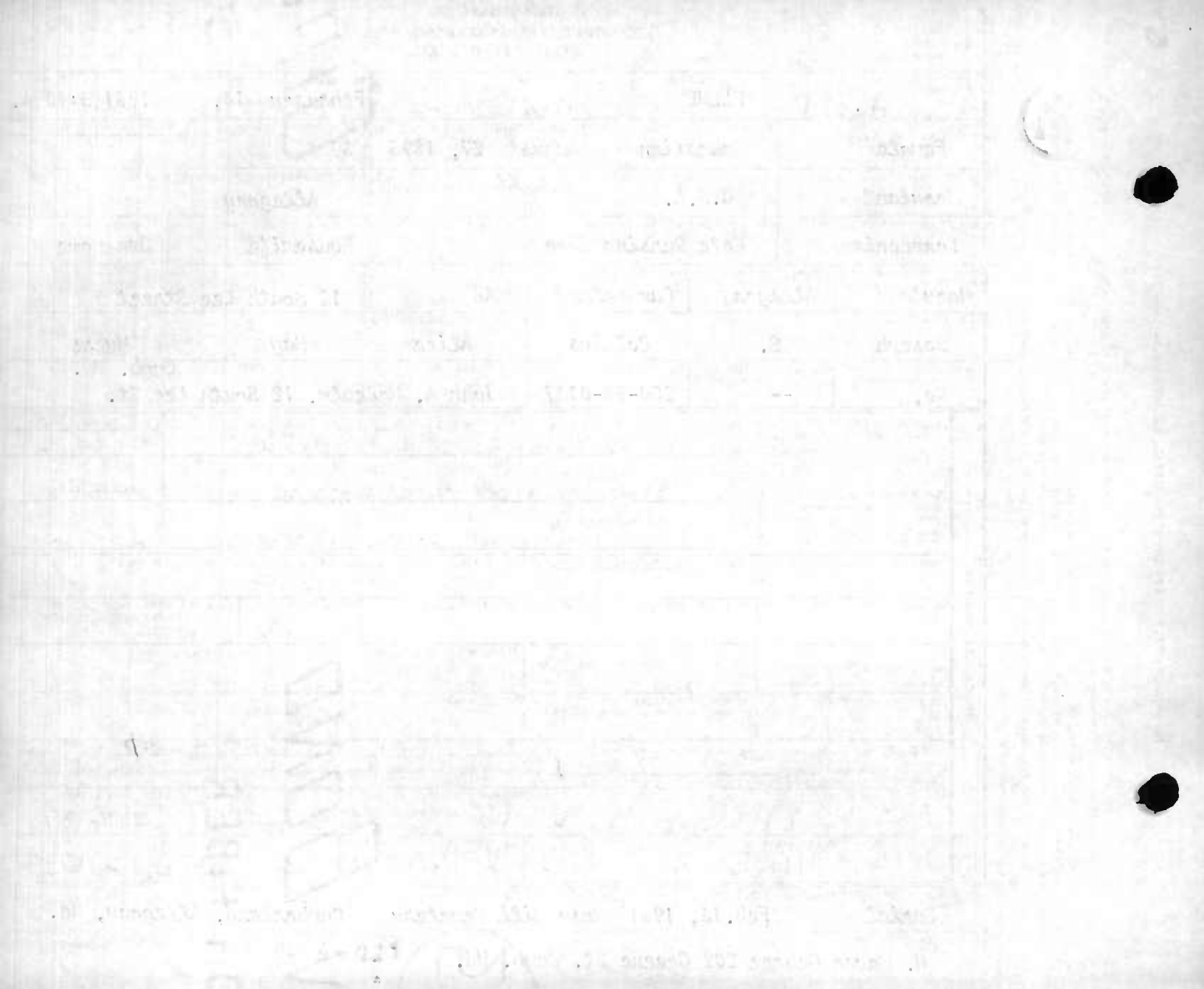
MEMORIAL MEDICAL BUILDING  
CHAMBERLAND, MARYLAND 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Hazel ELEM Malcolm				February 14, 1981 3:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		August 27, 1893		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Allegany MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lonaconing		Egle Nursing Home		Housewife		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN				13e. STREET ADDRESS			
Maryland Allegany Cumberland				12 South Lee Street			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Joseph S. Collins				Alice May Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				220-38-0137		John A. Malcolm, 12 South Lee St. Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Congestive Heart Failure							
4148							
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Ischemia							
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
				P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from Dec. 1979 to Feb. 14, 1981, that (I) (we) lost the deceased alive on Feb. 7, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE						22c. DATE SIGNED	
L.R. MIKES JR MD						2-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS	
L.R. MIKES JR MD						LONA CONING MD, 21539	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Feb. 16, 1981		Rose Hill Cemetery		Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
H. Wayne George				202 Greene St. Cumb. Md.		FEB 24 1981	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(V.R. A15 ME (5))  
15M 7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03396							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Gary Edward Marsh</b>										2a. DATE KNOWN OF DEATH ESTI- MATED MONTH DAY YEAR <b>2 18 19 81</b>										2b. HOUR P.M. <b>4:15</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 31 1949</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>31 YRS.</b>		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 18 19 81</b>										2d. HOUR P.M. <b>7:00</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>										MD.					
10. CITY OR TOWN OF DEATH <b>Frostburg</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>East Main Street Frostburg Md.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clergymen</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Church Work</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																											
13a. STATE <b>Md.</b>				13b. COUNTY <b>Allegany</b>				13c. CITY OR TOWN <b>Frostburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>216 Shaw St. Frostburg Md.</b>													
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Robert Marsh Sr.</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Mae Jones</b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				(IF YES, GIVE WAR OR DATES) <b>Vietnam Era</b>				16b. SOCIAL SECURITY NO. <b>215-56-9010</b>				17. INFORMANT ADDRESS <b>Vickie Marsh 216 Shaw St. Frostburg Md.</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries And Burns</b> 8129 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Vehicle Struck By Runaway Truck</b> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																											
19a. DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Vehicle Struck By Runaway Truck</b>																21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:15 P.M. 2 18 1981</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>East Main Street Frostburg Allegany Md.</b>																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>2/19/81</b>															
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic M. D.</b>				ADDRESS <b>Baltimore Pike, Cumberland Md.</b>																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/21/81</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westernport Allegany Md.</b>															
24. FUNERAL DIRECTOR NAME <b>Boal Funeral Service</b>										ADDRESS <b>Westernport Md. 21562</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1981</b>				25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

City	State	County	Address
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.

City	State	County	Address
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.

City	State	County	Address
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.

City	State	County	Address
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.

City	State	County	Address
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.
Chicago	Ill.	Cook	1234 N. Dearborn St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY RAY MASON						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 25, 1981		2b. HOUR 10:10 P <sub>M</sub>		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY Coal			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2, Box 159		
14. FATHER'S NAME FIRST MIDDLE LAST Wilson Mason				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Jane Burkholder								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Route 2, Box 159 Mrs. Elma Mason, Grantsville, Md. 21536								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe ASHD &lt; CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pulmonary emboli</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hx of CVA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>2-13</u> , 19 <u>81</u> , to <u>2-25</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2-25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>John M. D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-26-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHANNA, JOHN M.D.				22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 28, 1981		23c. NAME OF CEMETERY OR CREMATORY Bitteringer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bitteringer, Garrett, Md.						
24. FUNERAL DIRECTOR'S NAME <u>Dr. Lynn Newman</u> NEWMAN FUNERAL HOME; P.O. BOX 267, GRANTSVILLE, MD.				25. DATE PREPARED BY REGISTRAR 1981		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

(M)

February 17, 1971  
Sacramento Heart Hospital  
Sacramento, California  
95805  
P.O. Box 123  
Sacramento, California  
95805

Handwritten notes and signatures, including a large circular stamp.

POSTAL SERVICE  
Sacramento, California  
95805



72

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-7000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 3 9 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edith PEARL Mauzy</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>2/24/81</b>		7b. HOUR <b>3:45A<sub>M</sub></b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 8 1908</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY MD.</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cumberland Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>ALLEGANY</b> 13c. CITY OR TOWN <b>FLINTSTONE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>RFD# 2 BOX# 131</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EARL SPITZNAS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PEARL THORPE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-80-0371</b>	17. INFORMANT ADDRESS <b>CARL MAUZY 214 CUMBERLAND ST., CUMBERLAND MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1/20 8 19 81</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1/20 81 2/24 81</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/20 81</b> to <b>2/24 81</b> , that (I) (we) last saw the deceased alive on <b>2/20 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hale</b>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/24/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. HAZ MOS</b>			22e. ADDRESS <b>CUMBERLAND, MARYLAND 21502</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>FEB. 26, 1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FLINTSTONE ALLEGANY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD</b>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 26 1981</b>		

WEDNESDAY

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NOTICE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 0 3 3 9 9				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HARRY KNOX MCCLURE					2a. DATE OF DEATH FEBRUARY 14, 1981			2b. HOUR 2:00P <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-15-95		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) McKeesport, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Ser. Sta.		12b. KIND OF BUSINESS OR INDUSTRY Retail Gas	
13a. STATE Pa.					13b. CITY OR TOWN Salisbury		13c. STREET ADDRESS R.D. # 1		
14. FATHER'S NAME Quincy Adama McClure					15. MOTHER'S MAIDEN NAME Ellen Bradbury				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 172-28-6847		17. INFORMANT ADDRESS J.W. McClure Grant St. Salisbury, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease; Rheumatic Heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>History of Carcinoma of Prostate</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE VICTOR R. FELIPA M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR R. FELIPA M.D.					22e. ADDRESS 925 BISHOP WALSH RD, CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-17-81		23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Somerset Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME, 101 GRANT ST., SALISBURY, PA.					25a. DATE REC'D. BY REGISTRAR FEB 23 1981		25b. REGISTRAR'S SIGNATURE		

VERBODEN TOEGANG

• 647 • VOLUME 142 • 13 FEBRUARY 1994 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAMES MICK					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1981			2b. HOUR A 3:50 M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 8, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY, MD.			
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Cresaptown,					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS McMullen Hwy.		
14. FATHER'S NAME FIRST MIDDLE LAST Elexander -- Mick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe -- Wolford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214-05-8052		17. INFORMANT ADDRESS Mrs. Sylvia K. Mick, P. O. Box # 5342 Cresaptown, Md. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>widespread metastatic ca of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ca of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD, CHF</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30</u> , 19 <u>80</u> , to <u>2-11</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2-10</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (did not) view the body after death.									
22b. SIGNATURE John Mehanua			DEGREE M.D.			ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 2-11-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANUA, M.D.			22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MARYLAND 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/13/81		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland		
24. FUNERAL DIRECTOR'S NAME Wayne George			202 GREENE STREET CUMBERLAND, MD. 21502			25. DATE REC'D. BY REGISTRAR FEB 17 1981		26. REGISTRAR'S SIGNATURE	

BP



DATE: FEBRUARY 12, 1962

ALLIANCE COUNTY

SACRED HEART HOSPITAL

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUENNA M. MILLESON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 4, 1981		2b. HOUR 1:35 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 5, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Allegany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Allegany	13c. STREET ADDRESS Rt. #3, Box 98, Bedford Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Yergan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-4733	17. INFORMANT ADDRESS J. Forrest Milleson, Cumberland, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

0799

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/20, 1981, to 2/4, 1981, that (I) (we) last saw the deceased alive on 2/4, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE J. H. Elder MD	DEGREE MD	22c. DATE SIGNED 2/4/81	22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THADDEUS H. ELDER
22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG.		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 7, 1981	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial P.	23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME ADDRESS William G. Kight, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR FEB 13 1981	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed immediately after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1901 1902 FEBRUARY 1903 JOURNAL

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CUMBERLAND MEMORIAL HOSPITAL



DR. THADDEUS H. ELLER MEMORIAL HOSPITAL MEDICAL BLDG.

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03402	
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Harrison Mitter</b>						2a. DATE KNOWN OF DEATH MONTH <b>2</b> DAY <b>18</b> YEAR <b>81</b>		2b. HOUR <b>4:15</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>21</b> YEAR <b>1919</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>					
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>East Main Street Frostburg Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Luke</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>221 Fairview St. Luke Md.</b>			
14. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b></b> LAST <b>Mitter</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>Morehead</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>236-03-3980</b>		17. INFORMANT ADDRESS <b>Frances Mitter 221 Fairview St. Luke Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries And Burns</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Vehicle Struck By Runaway Truck</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:15 P.M. 2 18 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Vehicle Struck By Runaway Truck</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET <b>East Main St.</b> CITY OR TOWN <b>Frostburg</b> COUNTY <b>Allegany</b> STATE <b>Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>2/19/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic M. D.</b>				ADDRESS <b>Baltimore Pike, Cumberland Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/21/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Memorial Gardens</b>		23d. LOCATION CITY OR TOWN <b>Keyser</b> COUNTY <b>Mineral</b> STATE <b>W. Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Boal Funeral Service</b> ADDRESS <b>Westernport Md. 21562</b>				25a. DATE RECD. BY REGISTRAR <b>2/24/81</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FAY A. MONTGOMERY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1, 1981		2b. HOUR 0830 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Pipefitter	12b. KIND OF BUSINESS OR INDUSTRY Fiber Co.	
13a. STATE MD.	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 611 Bedford St.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Montgomery		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annetta E. Oats			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWI		16b. SOCIAL SECURITY NO. 214-07-4600	17. INFORMANT ADDRESS Ruth Blacklin Cumberland, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: 5501 IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Postop. Uncontrolled Bleeding @ myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancerous of Lung, Coronary Artery Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>4 months</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <i>Richard L. Snider MD</i>		22b. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502		22c. DATE SIGNED 2/2/81	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 4, 1981	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial P.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD		25a. DATE REC'D. BY REGISTRAR FEB 6 1981	
				25b. REGISTRAR'S SIGNATURE <i>P. H. K. Kight</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FEBRUARY 1, 1961 0870

MONTGOMERY

A.

RAY



CUMBERLAND, MD. MEMORIAL HOSPITAL



NOTED:

DR. RICHARD L. SMITH

MEMORIAL MEDICAL BUILDING  
CUMBERLAND, MARYLAND 21502

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03404	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick John Mortzfeldt										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9:30 P. M. Feb. 2 19 81	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 1, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Feb. 2, 19 81 9:30 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital D.O.A.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Steel	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. # 3 Box 222			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Mortzfeldt										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Raschke	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-05-7775		17. INFORMANT Eula P. Mortzfeldt		ADDRESS Rt. #3 Box 222 Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Generalized 1629 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CA of Lungs (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months 1 Year	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Benedict Skitarelic				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED Feb. 2, 1981			
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D.				ADDRESS Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Allegany Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Silcox-Merritt Funeral Ser. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR FEB 9 1981		25b. SIGNATURE					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 19a & b G553 3/2/81 dad										STATE OF MARYLAND														
1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
CERTIFICATE OF DEATH										REG. NO. 8103403														
1 DECEASED NAME (TYPE OR PRINT)					FIRST MARGARET ELLEN MUIR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR									
										FEBRUARY 06, 1981					9:15A <sub>M</sub>									
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS														
Female		White		MONTH - 26 - YEAR 1899		82		MONTHS		DAYS		HOURS		MIN.										
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH																		
Md		U.S.A.				ALLEGANY COUNTY, MD																		
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OR PRINT)					12b. KIND OF BUSINESS OR INDUSTRY									
Cumberland					SACRED HEART HOSPITAL					housewife														
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
Md										Allegany		Nikep		YES <input type="checkbox"/> NO <input type="checkbox"/>										
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST					FIRST MIDDLE LAST																			
Fred Clupp					Nancy Coleman																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS									
no										Eugene Muir					Nikep, Maryland									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Cardiovascular Arrest																								
7854																								
DUE TO, OR AS A CONSEQUENCE OF																								
(b) Coronary Artery Failure, PEVIO																								
DUE TO, OR AS A CONSEQUENCE OF																								
(c) pulmonary edema, Asphyxiation																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
Pneumonia RLL																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
1/29/81					Gangrene of Rt. foot					YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
					P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION														
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK										STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from Jan 20, 19 81, to Feb 6, 19 81, that (I) (we) last saw the deceased alive on Feb 5, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b. SIGNATURE					22c. DATE SIGNED				
															DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS														
SHIN KIM. M.D.										90 MAIN STREET, WESTERNPORT, MD. 21562														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
Burial					2/9/81					Laurel Hill Cemetery					CITY OR TOWN COUNTY STATE									
															A. Md									
24 FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
EICHORN FUNERAL HOME										8 MAIN STREET, LONA CONING, MD.										FEB 13 1981				



RECEIVED  
FEB 11 1961  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-83 BY 60322  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

RECEIVED  
FEB 11 1961  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 0 3 4 0 6	
CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MAIDA Eunice Niland</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02/ 04/81</b>		2b. HOUR <b>11:20A</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 24 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CUMBERLAND NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>COYLE H. TEWELL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NORA BARTHOLOW</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-10-9273</b>		17. INFORMANT ADDRESS <b>DOROTHY BLACK 407 ALLEGHENY STREET HUNTINGDON PENNA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cat Cell Carcinoma of Lung</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. ??</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary Emphysema</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pulmonary Emphysema</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>WENT</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> 19 <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>02-04-1981</b> , to <b>02-04-1981</b> , that (I) (we) lost saw the deceased alive on <b>02-04-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Martin M. Rothstein M.D.</b>			22c. DATE SIGNED <b>02/04/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN M. ROTHSTEIN M.D.</b>			22e. ADDRESS <b>48 BROADWAY - FROSTBURG - MD. 21532</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB 7, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MD.</b>		23e. DATE REC'D BY REGISTRAR <b>FEB 9 1981</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SILCOX MERRITT FUNERAL SERVICE CUMBERLAND MD.</b>					

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THE UNIVERSITY OF CHICAGO

105

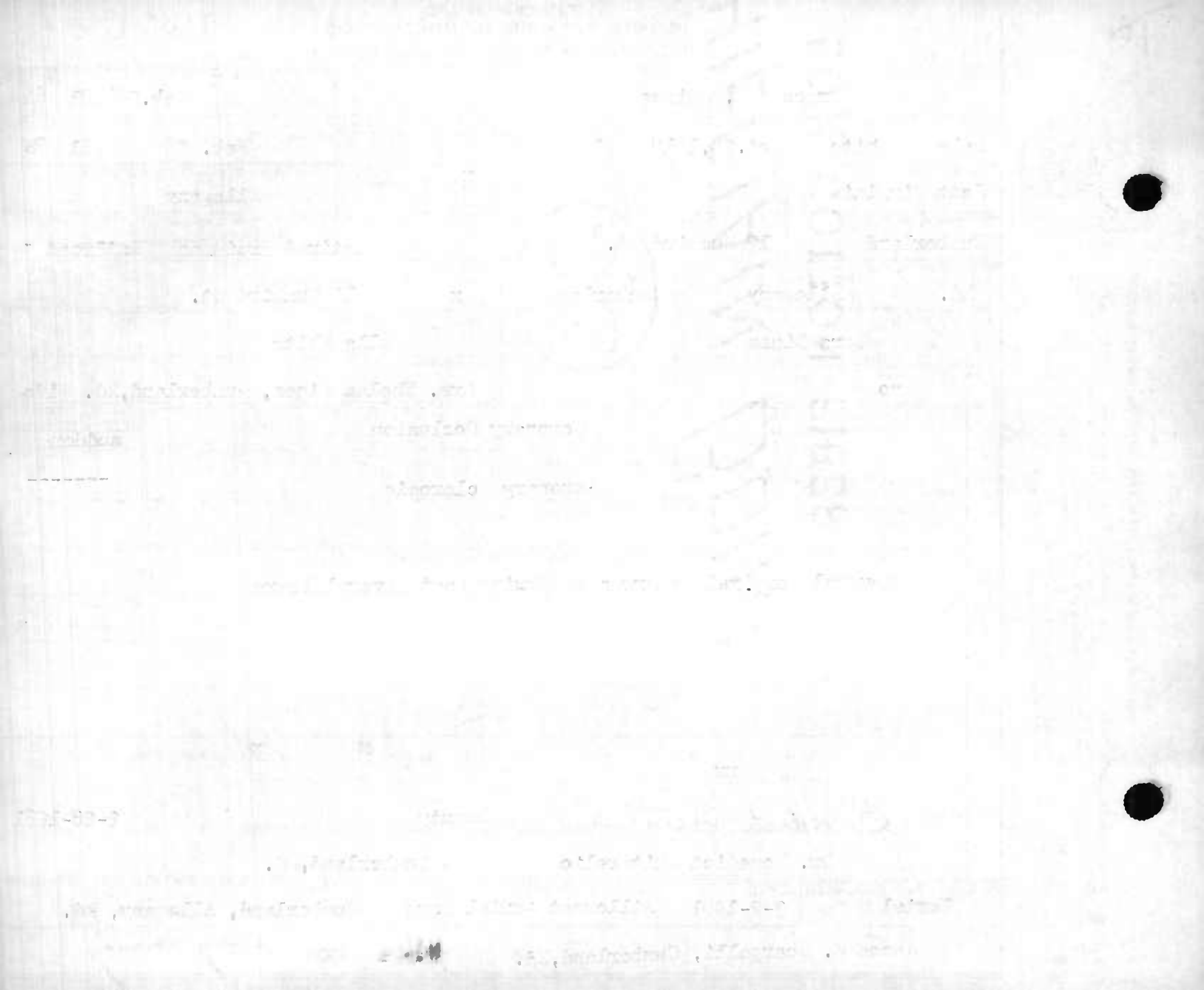
6234

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03407	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Bruce V. Nines</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Feb. 28 1981</b>		2b. HOUR <b>6A</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 28, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17 Humbird St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Trainman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17 Humbird St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ezra Nines</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella White</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Mrs. Thelma Nines, Cumberland, Md. Wife</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>										<b>sudden</b>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <b>Coronary Sclerosis</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
<b>Several Cerebral Hemorrhages During Past Several Years</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER		DATE SIGNED <b>2-28-1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Benedict Skitarelic</b>				ADDRESS <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3-2-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 0 3 4 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND W. NIXON				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1981		2b. HOUR MIN. 11:40A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Brewing Co.	
USUAL RESIDENCE (IF NUMBER HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MIDDLE LAST Md. Allegany				13b. CITY OR TOWN Cumberland		13c. STREET ADDRESS 115 Virginia Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John I. Nixon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Maloney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-18-2490		17. INFORMANT ADDRESS Mr. Bernard Nixon, Cumberland, Md. Brother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>from - r Septicemia.</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>from - r pneumonia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Alcoholism, D. detox Kelso, Cora</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/16/81</u> , to <u>2/18/81</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE (TYPE OR PRINT) DR. NAGARATNAM RANJITHAN				22c. DATE SIGNED		22d. ADDRESS MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-12-1981		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.				25. DATE REC'D. BY REGISTRAR FEB 17 1981		25b. REGISTRAR'S SIGNATURE	



RECEIVED 10, 1941 11:00 AM

MEMORIAL HOSPITAL

NOV 10 1941



MEMORIAL HOSPITAL

NOV 10 1941



MEMORIAL HOSPITAL  
CUMBERLAND, MD. 21032

MEMORIAL HOSPITAL

NOV 10 1941  
RECEIVED 10, 1941 11:00 AM

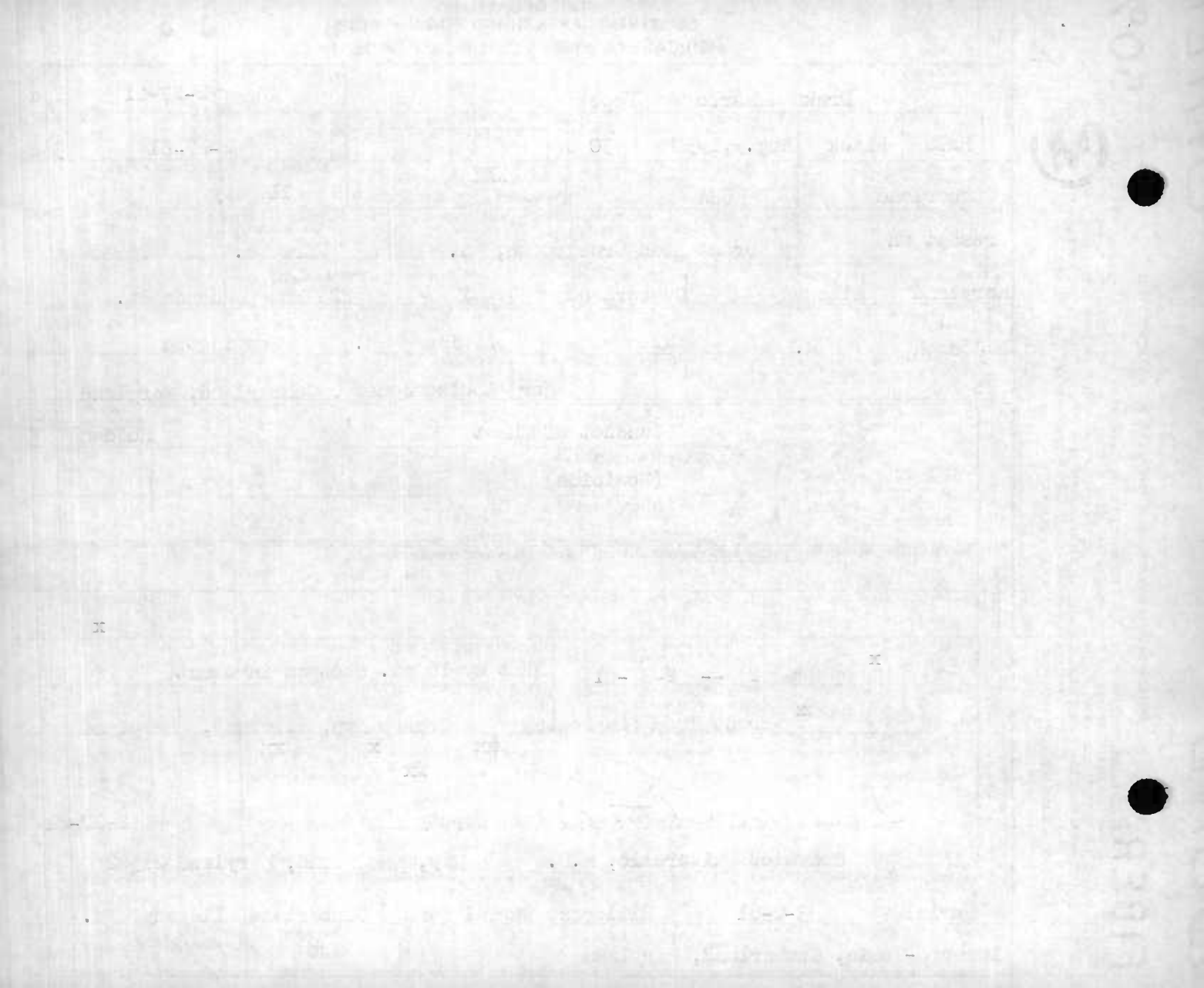
BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03409	
1. DECEASED NAME (TYPE OR PRINT) <b>Drake Marlo Pope</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>2-27-81</b> 19		2b. HOUR <b>2 a</b> M		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 9, 1950</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD <b>2-27-81</b> 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cumberland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cresaptown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brant Road Cresaptown, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tire Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tires</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>225 Independence St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph R. Pope</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise E. Washington</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>Mary Louise Jones</b>		17. INFORMANT ADDRESS <b>Cumberland, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of Chest</b> 9651 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>(Homicide)</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2 - AM 2-27-81</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2 - AM 2-27-81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot by 16 ga. shotgun in chest</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Brant Road (in house)</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Cresaptown, Allegany, Maryland</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>2-27-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict Skitarelic, M.D.</b>				ADDRESS <b>P#9, Cumberland, Maryland 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>3-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leasure-Stein, Cumberland, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 1 0

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELENA VERONICA RACCO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 6, 1981</b>			2b. HOUR <b>9:50 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegeny</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>W. Va.</b>			13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Yes</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS <b>41 Paxton Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Donnelly</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Fitzwilliam</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>236-28-2016</b>		17. INFORMANT <b>Michael Racco</b>		ADDRESS <b>75 Second Street Piedmont, W. Va. 26750</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>3580</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MYASTHENIA GRAVIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>15 YEARS</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/80</b> to <b>2/6/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>DR. JAMES M. RAVEN</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JAMES M. RAVEN</b>				22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BUILDING</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-7-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>EC Westernport Allegeny Md.</b>					
24. FUNERAL DIRECTOR NAME <b>William H. Fredlock</b> <b>William H. Fredlock</b>				ADDRESS <b>31 Jones St. Piedmont, W. Va.</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEMORIAL HOSPITAL

February 6, 1981

MEMORIAL HOSPITAL

Office

on

at

to

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

*James M. Davis*

JAMES M. DAVIS

MEMORIAL HOSPITAL

2/8/81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FURNISH COPIES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03411	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy E. Reinhard										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 2-3-1981	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/15/1915		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS 65		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD Feb. 3 1981	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 812 North Ave. Roeth Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.										13b. CITY OR TOWN Allegany	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET ADDRESS 812 Roeth Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John L. Behon										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rusyn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mr. Michael Behon, Akron, Ohio, Brother			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Benedict Skitarelic				TITLE (SPECIFY) Deputy				DATE SIGNED 2-3-1981			
EXAMINER'S NAME (TYPE OR PRINT) Dr. Benedict Skitarelic MD				ADDRESS Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 5, 1981		23c. NAME OF CEMETERY OR CREMATORY SS. Philip & James Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Meyersdale, Pa.	
24. FUNERAL DIRECTOR NAME James F. Searpelli						ADDRESS Cumberland, Md.					
25a. DATE REC'D. BY REGISTRAR FEB 6 1981						25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION



[The main body of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be organized into sections, possibly separated by horizontal lines or headings, but the specific content cannot be discerned.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8 1 0 3 4 1 2										
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT		MIDDLE LEON		LAST RITCHIE		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 9, 1981		2b. HOUR 7:45 P.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 11, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Celanese Silk,		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 426 Fayette St.		
14. FATHER'S NAME FIRST MIDDLE LAST Irvin J. Ritchie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha C. Teets		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.						
16b. SOCIAL SECURITY NO. 217-10-4655		17. INFORMANT ADDRESS Mr. Leon R. Knetts, P. O. Box # 46 Rawlings, Md. 21557								
18. CAUSE OF DEATH (Enter only one cause for item 18a; if more than one, enter in item 18b.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 DUE TO OTHER REASON(S) (b) Cardiopulmonary arrest Carcinomatous Widespread CA of pancreatic mediastinum DUE TO UNKNOWN CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atherosclerosis - atherosclerosis, Atherosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18c, PART 2, OR PART 3)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Feb 6, 81 to Feb 9, 81						
22a. I certify that (I) (the hospital) attended the deceased from Feb 7, 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not see the body after death)										
22b. SIGNATURE Dr. Williams		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-9-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. T.E. WILLIAMS		22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/12/81		23c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland				
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR FEB 17 1981		25b. REGISTRAR'S SIGNATURE [Signature]						



REPORT FOR  
FEBRUARY 9, 1941

DATE: FEBRUARY 11, 1941

NAME: J. A. A.

CUMBERLAND MEMORIAL HOSPITAL

ADDRESS: 111-15-1555

ROOM: 11

DATE: FEBRUARY 11, 1941

*Handwritten notes:*  
Hickman - Williams  
111-15-1555  
111-15-1555

MEMORIAL MEDICAL BLDG.  
CUMBERLAND, MD. 21502

DR. T. E. WILLIAMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 4 1 3	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
WILLIAM THEODORE ROLLINS				FEBRUARY 7, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		Oct. 18, 1901	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
MD		USA		79 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
CUMBERLAND		MEMORIAL HOSPITAL		Allegany MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Saleman Ret.		Tobacco			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
W. Va. Mineral		Ridgeley		Rt. # 1	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John		Martha		Crowfis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-05-4208		William Gum Chesterland, Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Metastatic Carcinoma</u> <u>1889</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transitional Cell Carcinoma - Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>81</u> , to <u>2/7</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Walter N. Himmler</u>		MD.		<u>2/13/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DR. WALTER N. HIMMLER		MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MARYLAND 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb 10, 1981		Sunset Memorial P. Cumberland Allegany MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME William G. Kight ADDRESS Cumberland, MD		FEB 17 1981		<u>[Signature]</u>	

FEBRUARY 7, 1941 10:45 AM

WILLIAM THEODORE COLLINS



CUMBERLAND MEMORIAL HOSPITAL

1000 N. 10th St. York, Pa.

Memorial Hospital

1000 N. 10th St. York, Pa.

Memorial Hospital

X

DR. WALTER H. HINER

CUMBERLAND MEMORIAL HOSPITAL, YOK, PA.

FEB 7 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LULA FLOSSIE ROY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20, 1981</b>		2b. HOUR <b>8:30 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 30, 1900</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		9b. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.		10. CITY OR TOWN OF DEATH <b>Cumberland</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Allender</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		
17a. SOCIAL SECURITY NO. <b>217-10-63220</b>		17b. INFORMANT <b>Charles A. Roy, Cumberland, Maryland</b>		17c. ADDRESS <b>12009 Iris Ave. Potomac Pk.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.H.F. &amp; acute pulmonary edema</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD &amp; diabetes</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-21, 1981</b> to <b>2-20, 1981</b> , that (I) (we) last saw the deceased alive on <b>2-20, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Uriel Velandia M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>URIEL VELANDIA, M.D.</b>		22e. ADDRESS <b>924 SETON DRIVE, CUMBERLAND, MD. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 24, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Pk. Cumberland Allegany Md.</b>		
24. FUNERAL DIRECTOR NAME <b>KIGHT FUNERAL HOME</b>		309 DECATUR STREET ADDRESS <b>CUMBERLAND, MD. 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1981</b>		

1961 FEBRUARY 20 10:50 P



ALLIANCE PARTY

EMERGENCY RESERVE

UNITED STATES OF AMERICA

310 LEXINGTON STREET  
BOSTON, MASS. 02116



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WYPRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M7/77

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 03415	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank NMI Ryan						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2-10-81 19	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 3, 1895 85 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Hospital--DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
12b. KIND OF BUSINESS OR INDUSTRY Farm		13a. STATE Maryland					
13b. COUNTY Allegany		13c. CITY OR TOWN Eckhart		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Frostburg	
14. FATHER'S NAME FIRST MIDDLE LAST Jackson Ryan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Shingleton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 1		17. INFORMANT ADDRESS 220-10-2129A Delvin R. Ryan, Rawlings, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion, left Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Coronary Thrombosis (c) Coronary Sclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden " --11--	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Old Myocardial Infarctions; Aspiration of stomach contents,						Terminal	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 2-10-81	
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic		ADDRESS RD 9, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 13 '81		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eckhart, Allegany, Md.	
24. FUNERAL DIRECTOR NAME Durst, Frostburg, Md. 21532		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 19 1981		REGISTRAR'S SIGNATURE [Signature]	





RECEIVED  
FEB 10 1961

FEB 10 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 1 0 3 4 1 6									
1. DECEASED NAME (TYPE OR PRINT) <b>DAVID AARON SEARS</b>									
2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 2, 1981</b>									
2b. HOUR <b>1035A</b>									
3. SEX <b>Male</b>			4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 18, 1980</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>6 15</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Oldtown</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Route 1, Box 275</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl D. Sears, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Brenda Cartwright Willison</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Carl D. Sears, Sr. Oldtown, Md. Father</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: <b>4659</b> IMMEDIATE CAUSE (a) <b>Sudden infant death syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>-L.R.E. U.R.I.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert D. Brodell MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Feb. 2, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert D. Brodell MD</b>					22e. ADDRESS <b>500 Greene St., Cumberland, Md. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 5, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oldtown Allegany Md.</b>		
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>					25. DATE REGD. BY REGISTRAR 26. REGISTRAR'S SIGNATURE <b>FEB 18 1981</b>				



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WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 0 3 4 1 7					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BURNEY B. SHERMAN					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1981			2b. HOUR 1:55 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Conductor		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Lincoln St.		
14. FATHER'S NAME FIRST MIDDLE LAST George T. Sherman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Rumers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-5640		17. INFORMANT ADDRESS Mr. Burney B. Sherman Jr. Ariz. Son						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic obstructive pulmonary disease</i> 1850 <i>Advanced metastatic CA of prostate</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>due to chronic obstructive pulmonary disease</i> (b) <i>due to chronic obstructive pulmonary disease</i> (c) <i>due to chronic obstructive pulmonary disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>ASCVD</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (HOMER, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 2-18-81				
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 18 1981</i> to <i>Feb 18 1981</i> that (I) (we) last saw the deceased alive on <i>Feb 18 1981</i> and that (in [my] [our] opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Terry Williams</i>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS		22d. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MARYLAND 21502		22e. DATE SIGNED 2-18-81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-22-1980		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.		23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md.					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAWRENCE SCOT SHOEMAKER</b>						<b>FEBRUARY 20, 1981</b>						<b>9:05A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 24 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WV</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY, MD.</b>							
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Orchard worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Orchard</b>				
13a. STATE <b>WV</b>		13b. COUNTY <b>Hampshire</b>		13c. CITY OR TOWN <b>Purgitsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rural</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Arnold Shoemaker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Oddie Elda Flemming</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>232-26-3316A</b>		17. INFORMANT ADDRESS <b>Myrtle Shoemaker Purgitsville, WV 26852</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma lung late stage</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 months</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>2/20/81</b> to <b>2/20/81</b> , that (I) (we) last saw the deceased alive on <b>2/20/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Sivan A. Pillai</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/20/1981</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIVAN A. PILLAI, M.D.</b>				22e. ADDRESS <b>915 SETON DRIVE, CUMBERLAND, MD. 21502</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/23/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Pine Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Purgitsville Hamp. WV</b>							
24. FUNERAL DIRECTOR NAME <b>SHAFFERS FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1981</b>				25b. REGISTRAR'S SIGNATURE					

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ALLEGANY COUNTY

SOUTH WEST HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 4 1 9	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIE M. SHOOK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 18, 1981</b>		2b. HOUR <b>2:45 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 9, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>LONACONING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>MAIN STREET</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES GROVES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>COLLISTA DYE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N.A.</b>	17. INFORMANT ADDRESS <b>MRS. GEORGE SHOOK, RT.3, BOX 461, FROSTBURG</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 18, 1981</b> to <b>Feb. 18, 1981</b> , that (we) last saw the deceased alive on <b>Feb. 18, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE OF PHYSICIAN <b>Leslie R. Miles</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LESLIE R. MILES, M.D.</b>				22e. ADDRESS <b>55 JACKSON ST., LONACONING, MARYLAND 21539</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/20/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG, ALLEGANY, MD.</b>
24. FUNERAL DIRECTOR <b>Sowers Funeral Home</b> 60 W. MAIN STREET FROSTBURG, MARYLAND 21532					

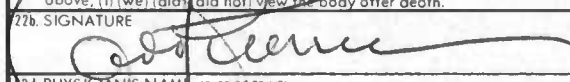
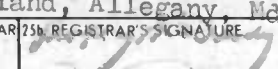
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
ARTHUR H. SMITH				FEBRUARY 25, 1981				7:15 PM			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		June 14, 1904		76		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL				Retired Conductor		railroad			
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
W. Va.				Allegany		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Paw Paw, W.Va. Side Maryland			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Norman Smith				Alice Mc Gee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no						Mr. Arthur & Mr. Kenneth Smith, Sons					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 8560 IMMEDIATE CAUSE (a) Cardioresp. + renal failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) TOXIC EPIDERMAL NECROLYSIS											
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Hypersensitivity Reaction										own	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) EPIDERMAL CARCINOMA of the lung											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AMADO P. TORRES						22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				2-28-1981		St. Marys Cemetery		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						MAR 2 1981					

FEBRUARY 22, 1961 7:12

ARTHUR H. SMITH

CURBERLAND MEMORIAL HOSPITAL

DR. AMADO P. TORRES  
MEMORIAL HOSPITAL MEDICAL BLDG.

2-22-1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 AND 6 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 03421	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) <b>IRIA Thornton SMITH</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>2-10-81</b>				2b. HOUR <b>2 a M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 30, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>D O A Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Atomic</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Central Y M C A</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Smith</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W W II 232-28-7434</b>		17. INFORMANT <b>Agnes Green</b>				ADDRESS <b>Md. 21502 1021 National Hwy. LaVale</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> (c) <b>SUDDEN</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>2-10-81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Benedict skitarelic, M.D. R#9, Cumberland, Maryland 21502</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Gap Veterans</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hafer, John J. LaVale Md. 21502</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Litky</b>					

U.S. DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL

Max LIMA Thornton

July 30, 1974

Virginia U.S.A. x Allegory

Conferland D O A Memorial Hospital Engineer Atomic

Ms. Allegory Conferland x Central Y M C A

Unknown Smith TRINITY

Yes V W II 523-28-74-44 Lynne Green 1021 National Hwy. Javala MS. 21502

John L. Javala  
May 1981 Weekly Copy Veterans  
Conferland Allegory



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 0 3 4 2 2	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) VERONICA V. SMITH			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1981		2b. HOUR 11:00A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 8, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Textile	
13a. STATE W. Va.			13b. COUNTY Morgan	13c. CITY OR TOWN Paw Paw	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Andrew P. Spearman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose F. Neusch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Husband Mr. Arthur H. Smith Paw Paw, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4560 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) Gastrointestinal bleeding (c) Bleeding esophageal Varices.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from 1/27/81 to 2/2/81, that (we) last saw the deceased alive on 2/2/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. S. Nathan		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. S. NATHAN		22e. ADDRESS MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 5, 1981	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR FEB 6 1981		25b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Warden</b> First <b>T.</b> Middle <b>Tharp</b> Last			2a. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>1981</b>			2b. HOUR <b>1700</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7/13/1909</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Allegany Co. Nursing</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Printer (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Print Shop</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Virginia Avenue</b>	
14. FATHER'S NAME <b>Benjamin Tharp</b> First <b>Tharp</b> Middle <b>Tharp</b> Last			15. MOTHER'S MAIDEN NAME <b>Ethelyn Fisher</b> First <b>Fisher</b> Middle <b>Fisher</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Phyllis Richardson</b> Address <b>Cresaptown, MD</b>		Sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Tongue with Neck Metastasis</b> <b>1416</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>approx. 6 m.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arterio-sclerosis</b> <b>Chronic Ischemic by-pass '75 Schizophrenia - 1960s M/L</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> , 19 <b>81</b> , to <b>2/9</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>2/9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. Topper</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>FEB 10 - 1981</b>			
22d. PHYSICIAN'S NAME (Type) <b>John A. Topper M.D.</b>				22e. ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-12-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial pk</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany MD</b>			
24. FUNERAL DIRECTOR <b>SCARPELLI FUNERAL HOME CUMBERLAND, MD</b>				25a. REC'D BY REGISTRAR <b>FEB 17 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
1/VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Arnold P			MIDDLE Tichnell			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 2-3-81			DAY 19			YEAR 19			2b. HOUR 9:07 P											
3. SEX Male			4. RACE White			5. DATE OF BIRTH (LAST BIRTHDAY)			11 10 1893			6. AGE (IN YEARS) (LAST BIRTHDAY)			87			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD			2-3-81			19			9:07 P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland						7b. CITIZEN OF WHAT COUNTRY? USA						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.																	
10. CITY OR TOWN OF DEATH Cumberland						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital---DOA												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner						12b. KIND OF BUSINESS OR INDUSTRY Coal											
13a. STATE Maryland												13b. CITY OR TOWN Allegany						13c. CITY OR TOWN Barton						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS Box 83					
14. FATHER'S NAME FIRST MIDDLE LAST William Tichnell												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Paugh																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 1 212-03-4772						17. INFORMANT ADDRESS Mary Nelson Barton, Maryland																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Coronary Sclerosis</b> (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____																								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ===											
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>												TITLE (SPECIFY) Deputy MEDICAL EXAMINER												DATE SIGNED 2-3-81											
EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D.												ADDRESS R#9, CUMBERLAND, MARYLAND 21502																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial												23b. DATE 2/6/81						23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Park						23d. LOCATION CITY OR TOWN COUNTY STATE Lavale Allegany Md.											
24. FUNERAL DIRECTOR NAME Boal Funeral Home												24b. ADDRESS Westernport, Maryland						25a. DATE REC'D. BY REGISTRAR FEB 9 1981						25b. REGISTRAR'S SIGNATURE <i>Anthony Maloney</i>											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Elma		MIDDLE Todd		LAST Todd		2b. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> 2/14/ 1981		2d. HOUR 6.15 M	
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 - 23 - 1913		6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 2/14/81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Moscow		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Barton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Moscow		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST William Fairgreive				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Lee				ADDRESS Rt. 1 Barton Moscow, Md			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Milton Todd				ADDRESS Rt. 1 Barton Moscow, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis Generalized</u> 1830 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <u>Carcinoma of Ovary</u> (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months 1 Year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER				DATE SIGNED 2/14/81			
EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic		ADDRESS Rt. 9 Cumberland, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/17/81		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Moscow A. Md			
24. FUNERAL DIRECTOR NAME Eichhorn Funeral Home		ADDRESS Lonaconing, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 23 1981					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 2 6

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LAVENE ETTA TWIGG			2a. DATE OF DEATH MONTH DAY YEAR 2-14-81			2b. HOUR 10:05 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 13 1906	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD				
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE WV 13b. COUNTY Hampshire 13c. CITY OR TOWN Greenspring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Nelson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta V. Haines				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-76-0989	17. INFORMANT ADDRESS Maxine Gulbranson, Ft. Ashby, WV				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstance arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> 2-3 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cholecystitis and cholelithiasis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 12/12/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gallstones		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>81</u> , to <u>2/14</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Andrew Stasko MD</u>		22c. DATE SIGNED 2/14/81			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW STASKO, MD		
22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD 21502		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/17/81		23c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greenspring Hampshire WV	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer SHAFFERS FUNERAL HOME, 230 E MAIN ST. ROMNEY W. VA.				25. DATE REC'D. BY REGISTRAR FEB 18 1981		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1 - STATE REGISTRAR					8 1 0 3 4 2 7 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Daniel Earl Watkinson					2a. DATE OF DEATH MONTH DAY YEAR 2/24/81			2b. HOUR 1:45p M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lonaconing		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13e. STREET ADDRESS 1 Kaylor Circle			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Watkinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice DeVault					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unknown				16b. SOCIAL SECURITY NO. 216-07-2314		17. INFORMANT ADDRESS J Mallery 48 Tarn Terrace, Frostburg, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Advanced Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>81</u> , to <u>Feb 24</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles H. Chang</u>					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANG. H. OH					22e. ADDRESS 48 TARN TERRACE, FROSTBURG, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/26/81		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Moscow Allegany Md.		
24. FUNERAL DIRECTOR NAME Eichhorn Funeral Home					ADDRESS 8 East Main Lonaconing, Md.		25a. DATE REC'D. BY REGISTRAR MAR 2 1981		25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 1 0 3 4 2 8					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
LILLIE M. WESTFALL					FEBRUARY 22, 1981					
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 11, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84		7b. HOUR PM 9:28		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		12b. KIND OF BUSINESS OR INDUSTRY --		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				
13a. STATE W. Va.					13b. COUNTY Mineral		13c. CITY OR TOWN Keyser		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Albert					15. MOTHER'S MAIDEN NAME Martha J. Shimp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 234 58 1234		17. INFORMANT Arlie T. Westfall 49 D St. Keyser, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refactory CHF</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/22/81</u> 19 <u>81</u> , to <u>2/22/81</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2/22/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death.</u>										
22b. SIGNATURE <u>P. Halmos</u> MD					22c. DATE SIGNED 2/23/81			22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER HALMOS		
22e. ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25 Feb 81		23c. NAME OF CEMETERY OR CREMATORY Potomac Mem. Gardens		23d. LOCATION City or Town County State Keyser Mineral W. Va.				
24. FUNERAL DIRECTOR NAME Allen M. Rotruck					25a. DATE REC'D BY REGISTRAR FEB 27 1981					
25b. REGISTRAR'S SIGNATURE <u>Harry Halmos</u>										



Female	White	May 11, 1896	84
Virginia	U.S.A.	X	Allegany
Homemaker			
W.Va.	Mineral	Keyser	X
Albert	Kane	Martha	J.
No	234 58 1234	Artie T. Westfall	49 D St. Keyser, W.V.

*[Faint, illegible handwritten notes and stamps in the center of the page.]*

Allen H. Rotruck Keyser, W. Va. Feb 11 1901  
Gardens Keyser Mineral W.Va. 22 Feb 01  
Potomac Nat. Gardens Keyser Mineral W.Va.



REG. NO.

### MEDICAL CERTIFICATION

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5)  
15M 2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 0 3 4 3 0	
1. FOR STATE REGISTRAR										REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
Bernarda Winner					2/20/81					8:15aM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		1 / 01 / 98		83		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Allegany MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frostburg, MD.		Frostburg Community Hospital				Homemaker		Own Home			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Allegany		Mt Savage		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16 Columbia Ave		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Joseph Miller					Martha Brailer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no			214-74-2516		J Mallery 48 Tarn Terrace, Fbg., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										12 HRS. ?!	
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>											
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACVD</u>										20 yrs !?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
NONE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
NONE			✓				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
NONE			P.M. 19		✓						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
✓					✓						
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1965</u> to <u>20 FEBRUARY 81</u> , that (I) (we) last saw the deceased alive on <u>20 FEBRUARY 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Martha Brailer</u>					DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 02-20-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. Rothstein					22e. ADDRESS 48 Broadway, Frostburg, MD. 21532						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Feb. 23, 1981		St. Patrick Cemetery			Mt. Savage, Allegany, Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Durst Funeral Home, Frostburg, Md. 21532					FEB 27 1981		<u>Patrick McCreedy</u>				

Dr. M. Rothenstein  
 48 Frothingham, Frothingham, MA. 01532  
 Feb 27 1981  
 Dr. M. Rothenstein, 48 Frothingham, Frothingham, MA. 01532  
 Feb 23, 1981 St. Patrick Cemetery, Mt. Savage, Allegheny, Md.

48-76-2512 9 Military St. Term Terrace, Fdb., Md.  
 48-76-2512 9 Military St. Term Terrace, Fdb., Md.

Jackson Miller  
 Maryland, Allegheny, 76 Savage  
 18 Columbia Ave

Frothingham, Md. Frothingham Community Hospital  
 Homemaker  
 Maryland, USA  
 Female  
 White  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jeffrey H. Wood</b>		2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2-8 19 81</b>		2b. HOUR OF DEATH <b>6:45 P</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 16, 1974</b>	6. AGE (IN YEARS) LAST BIRTHDAY) <b>6</b> YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Feb. 8 19 81</b>
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOA Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>
13a. STATE <b>W. Va.</b>		13b. COUNTY <b>Mineral</b>	13c. CITY OR TOWN <b>Ridgeley</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Robin Drive, Millersdale</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Wood</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sandra Kifer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. &amp; Mrs. Wm. H. Wood, Parents</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>3459</b> IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Epileptic Seizure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Epilepsy</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>minutes</b> <b>years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>Deputy</b>		MEDICAL EXAMINER DATE SIGNED <b>2-8-1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Benedict Skitarelic MD</b>		ADDRESS <b>Cumberland, Md.</b>			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-11-1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS		25. RECORDING STRAR 25b. REGISTRAR'S SIGNATURE	



RECEIVED  
JAN 10 1964  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-371011)  
FROM : SAC, NEW YORK (100-101011)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 3 4 3 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK WRIGHT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 28, 1981</b>		2b. HOUR <b>7:34A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 10, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Ret. Mgr.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. YMCA</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland,</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Wright,</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Hanawalt,</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes,</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W. W. # 1 212-12-8763</b>		17. INFORMANT ADDRESS <b>Mr. Gorman E. Getty, 831 Buckingham Rd. 21502</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4149 Ventricular fibrillation</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary Artery Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Senility</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27/81</b> to <b>2/28/81</b> , that (I) (we) last saw the deceased alive on <b>2/27/81</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD, ABIM</b>		22c. DATE SIGNED <b>2/28/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NAGARATNAM RANJITHAN</b>		22e. ADDRESS <b>MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/2/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyndman, Bedford, Penna.</b>
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b>		ADDRESS <b>202 Greene St. Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



FRANK C. T. T. FEBRUARY 28, 1941

MEMORIAL HOSPITAL, CHIMBERLAND, MD.

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